An exploration of therapist and patient factors and their relationship to outcome in "2+1" brief therapy

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An exploration of therapist and patient factors and their relationship to outcome in "2+1" brief therapy.

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Abstract.

Introduction: the area of process research has identified differences in the process of CB and PI therapy and has highlighted factors which contribute to outcome. The present research aimed to explore three factors, therapist focus, client experiencing and client cognitive change, in very brief 2+1 therapy, and explore their relation to immediate outcome as measured by the assimilation scale.

Method: intensive quantitative analyses of eight cases receiving 2+1 therapy was carried out. Four cases received CB therapy, four received PI therapy. Two of each showed 'good' and 'poor' outcome. Ten excerpts, rated in a previous project as significant, were used as items of analysis.

Results: PI therapists focused more than CB therapists on 'Constructing Meaning' (CM).Good outcome PI therapy showed a greater emphasis than poor outcome PI therapy on CM. PI therapy clients had higher levels of experiencing, which increased over therapy. Good outcome PI therapy was associated with higher EXP levels, good outcome CB therapy with lower levels of EXP. Good outcome CB clients had fewer negative self-statements. Movement on the assimilation model was associated with increased EXP levels in PI and fewer negative self-statements in CB therapy.

Discussion: results supported previous findings of differences in the process of CB and PI therapy. The mechanism of change in very brief CB and PI therapy are discussed, followed by implications for clinical practice and future research. Overall, findings suggest a picture of the process of therapy which may contribute to the clarification of the complex nature of change in psychotherapy and what is meant by therapeutic change.

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1. Introduction.

1.1 Psychotherapy research.

The most common focus of psychotherapy research to date has been outcome research which is designed to explore the impact of psychotherapy on individuals, couples and families. Conclusions of reviews and meta-analyses of outcome research have stated that "psychotherapy works" (Castonguay & Schut, in press), although sometimes showing limited sustained benefits (Westen & Morrison, 2001). Drawing away from the broader picture, efforts have been made to identify which psychotherapeutic approach is the most effective. Comparative research has found that, despite their distinct theoretical bases and use of wide ranging therapeutic techniques, different approaches to psychotherapy are equally effective – the so called Dodo bird verdict (Wampold et al., 1997). Both cognitive behaviour (CB) therapy and psychodynamic-interpersonal (PI) therapy have been shown to be effective interventions (e.g.Blagys & Hilsenroth, 2000; Kopta, Lueger, Saunders & Howards, 1999). It is possible that methodological weaknesses and inappropriate measurement tools have hindered research's sensitivity to differences inherent in different psychotherapeutic approaches (Westen & Morrison, 2001). For example, therapy mode is often the only variable studied in comparative investigations, ignoring other factors which could contribute to outcome such as patient characteristic and therapist skill (Kopta et al., 1999). Furthermore, the focus of outcome research on symptom improvement as the main measure of therapeutic change has

meant that many other indices of change such as increase in positive psychological factors may be ignored (e.g.Seligman, 2001).

An alternative explanation for the Dodo bird effect is that despite the use of superficially distinct techniques, all psychotherapeutic approaches revolve around a core element of effective common factors such as empathy and the therapeutic alliance (e.g. Stiles, Shapiro & Elliott, 1986). Indeed, common factors have been reported to contribute substantially to outcome (e.g. Castonguay, Goldfried, Wiser, Raue & Hayes, 1996). For example, Ablon & Jones (1999) found that common factors not explicitly related to any theory were associated with client change in both cognitive and interpersonal therapy approaches. However, on the other hand, it is possible that different psychotherapeutic approaches arrive at the same outcome points via a number of routes, using different techniques and strategies to travel: "more than one path to the mountain top" (Blagys & Hilsenroth, 2000). A body of literature documents a number of differences in content of cognitive-behavioural and psychodynamic therapies for example and their relation to outcome (as reviewed in Llewelyn & Hardy, 2001; Blagys & Hilsenroth, 2000). Rather than taking a position where *either* specific factors *or* common factors are considered the main contribute to outcome, some authors have argued that different therapeutic approaches adopt the core effective elements common to all therapies, but supplement these with techniques and factors specific to each therapeutic approach (e.g. Crits-Christoph, 1997). Identifying the

relative contributions of common and specific factors to outcome requires complex dismantling studies of process.

However, the Dodo-bird effect is not a view shared by all researchers, and moves are being made towards identifying the differential effects of therapies for specific clinical presentations, termed 'aptitude-treatment interactions' (ATIs; Snow, 1991). For example, cognitive-behaviuoral therapy is viewed as the most effective therapeutic intervention for panic disorder (e.g. Arntz & van den Hout, 1996). Indeed, the current drive for evidence based practice is built upon the findings that different therapies have different degrees of success with different clinical problems. For example, Roth, Fonagy, Parry & Target (1996) have developed a handbook detailing the most effective therapies for the most common mental health difficulties, while the Department of Health have provided guidelines for treatment choice for clinicians (DoH, 2001). Therefore, although different types of therapy may overall demonstrate equal effectiveness as described in the Dodo-bird verdict, certain therapies appear to be able to alleviate symptoms of distress in some disorders more than others. It is still unclear though how these differences occur and what elements of each therapy mode are the active ingredients in change. Process research is in a strong position to be able to explore these differences by describing and analysing the content of therapy, before going on the relate this content to outcome. In summary therefore, although the Dodo-bird effect and the search for prescribed therapies appear initially contradictory, at a more

detailed level they both imply that there may be differences in the process of different therapies, and that these are worthy of study.

Process research is the study of patient and therapist systems, the interactions between the two and the change processes these create (Greenberg & Pinsof, 1986). This method of research was developed firstly to describe what actually occurred in psychotherapy sessions through sensitive moment-by-moment analysis, and secondly, to investigate which elements of each psychotherapy approach contributed to change (Hardy, Shapiro, Stiles & Barkham, 1998). This latter method of relating process elements to outcome has been termed process-outcome research (Blagys & Hilsenroth, 2000).

The process of therapy however is complex, and research is inevitably constrained in its ability to study all the factors which contribute to the experience and outcome of therapy. It has been estimated that hundreds of thousands of interactions between the currently identified process factors would need to be studied in order to obtain a comprehensive picture of the process of therapy. The tendency has therefore been to focus on a small number of specific factors to study, which although providing relatively small findings in themselves, can contribute to the growing overall picture of the process of different therapies.

1.2 Factors in change.

Many factors have been studied through process-outcome research, such as the therapeutic relationship and client and therapist behaviours. Such generalised concepts have been dismantled into more manageable and potentially more useful units of measurement in order to study specific aspects of the relationship and actions of the client and therapist. Three concepts are of particular interest for the current research, therapist focus, clients' emotional experiencing and cognitive change in the client, all of which are clinically relevant and have been found to be predictors of outcome (Llewelyn & Hardy, 2001; Blagys & Hilsenroth, 2000). They are also well defined factors within psychotherapy, are not orientation specific and are open to assessment through validated coding schemes.

1.2.1 Therapist focus.

Increasing clients' awareness, self-knowledge and understanding is often seen as a major aim of psychotherapy, facilitated by the use of a number of therapeutic techniques such as 'therapeutic feedback', whereby clients are made aware of what they are thinking, feeling and doing through feedback from the therapist (Goldfried, Raue & Castonguay, 1998). Although therapist feedback is a common element of psychotherapy, the focus of feedback can differ according to the therapist's theoretical orientation. For example, therapists can feedback about feelings rather than thoughts, or focus more on current events rather than past events. What the therapist

focuses on has been found to differ between CB and PI therapists (Blagys & Hilsenroth, 2000). According to theoretical background, PI therapists would be expected to encourage patients to express their feelings, as emotions are considered to be the key to understanding (e.g. Messer, 1986). Although CB requires exploration of emotions in order to activate meaning structures, emphasis would be more on helping clients develop alternative perspectives in order to manage their feelings (Beck, Rush, Shaw & Emery, 1979). As expected, in a study of CB and PI therapy for clients with depression, Goldfried, Castonguay, Hayes, Drozd & Shapiro (1997) found that PI therapists focused more on emotions, interpersonal patterns and links between people and time periods, including the therapist in sessions, in exploring "what has not worked in the past". CB therapists on the other hand focused more on external circumstances, decision making, support-giving and the future i.e. what clients could do to "deal more effectively with events in the future". Both were consistent with the therapeutic stance of PI and CB therapy, the former exploratory and interpersonal, the latter more problem-focused (Stiles, Shapiro & Firth-Cozens, 1989). A similar study in a more naturalistic setting with very experienced therapists supported the findings that CB therapists were more likely to focus on future and that PI therapists placed greater emphasis on emotion (Goldfried et al., 1998). Fewer differences were found across therapy types however, suggesting that master therapists may adopt a more integrative approach. Using the scale of Therapist Focus on Action and Insight (TFAI; Samoilov, Goldfried & Shapiro, 2000) found that PI therapists focused more on the 'Constructing Meaning' (CM) scale,

which targets enhancing insight e.g. focusing on past events, unspecified thinking, feelings and wishes, within an emotional context. CB therapists were found to focus more on external factors included in the 'Facilitating Action' (FA) scale e.g. performance of specific actions, current situation and future events. There is therefore an empirical basis for suggesting that the focus of psychotherapeutic intervention by PI and CB therapists are different, but it is not known how this applies in very brief psychotherapy. Although it has been suggested that therapist focus relates to outcome (Castonguay & Schut, in press), it is not clear what the nature of this relationship is. It may be that focus is associated with outcome through a dose related relationship i.e. a quantitative relationship by which higher frequencies of occurrence is related to better outcome.

On the whole therefore, there is an empirical basis for suggesting that the therapist focus differs between CB and PI therapy. Whether these different foci are related to client change, both within the session and over therapy, is unclear. Finally, it is not known whether the therapist focus changes over the course of therapy.

1.2.2 Experiencing.

The therapeutic relationship is a dyadic one, requiring contribution from both elements of therapist and client to bring about change (Llewelyn & Hardy, 2001). On the whole, client variables have not been as frequently studied as therapist variables (Maione & Chenail, 1999). However, one

client variable which has been investigated is emotional involvement, which has been conceptualised as 'experiencing', an awareness of "the whole complexity of one's living" (Klein, Mathieu, Gendlin & Kiesler, 1969). Experiencing refers to the personal moment-by-moment awareness of self, encompassing thoughts, emotions and physiology, communicated in therapy by the client through active participation and open discussion of emotional difficulties. Clients with low levels of emotional experiencing tell narratives characterised by impersonal descriptions of external events. Narratives rich in broad exploration and integrative formulations of personal issues are reflective of higher levels of emotional experiencing. Research on experiencing, although providing important pointers, presents an equivocal picture of patterns over time and differences associated with therapy types and outcome.

Experiencing has been found to oscillate throughout sessions, but on the whole, higher levels of emotional experiencing are related to better outcome (e.g.Castonguay et al., 1996; Klein, Mathieu-Coughlan & Kiesler, 1986). The predictive validity of experiencing had been most strongly supported in client-centred therapies until the first study of experiencing in CB therapy (Castonguay et al., 1996) found that experiencing was related to improvement in depressive symptoms. Theoretically, CB therapy focuses on explaining and reducing emotion within a cognitive framework, rather than evoking and exploring emotion for its own end which could be argued to be more the focus of PI therapy (Messer, 1986). To this end, it would be expected that successful CB therapy would involve less

experiencing of emotions in order to achieve its aim, while PI therapy would require higher levels of emotional experiencing. Wiser & Goldfried (1993) studied experiencing levels in portions of CB and PI sessions which were rated as significant by the therapist i.e. considered to be most critical to client change. Clients receiving PI therapy tended to show higher experiencing levels in significant portions of the session than in non-significant parts. On the other hand, there was a trend for CB patients to show lower experiencing levels in significant portions than in non-significant portions of the session. Whether clients' levels of experiencing differ within very brief CB and PI therapy has not been investigated, nor has its relation to within session outcome as measured by the Assimilation model, (described later).

Clients' experiencing levels have been found to differ between CB and PI therapy. It is unclear whether these different profiles also occur in very brief CB and PI therapy. Furthermore, the relationship between experiencing and outcome in very brief CB and PI therapy has not been studied.

1.2.3 Cognitive change.

While it has been hypothesised that PI therapy focuses more on emotions, requiring high levels of emotional experiencing to bring about change, CB therapy alternatively requires identification and working through cognitions in order to produce change (Messer, 1986). The cognitive

mediation hypothesis suggests that negative feelings are mediated by negative thoughts about self, world and future, so that modifying such thoughts during sessions would reduce the negative feelings (Tang & DeRubeis, 1999). Negative thoughts represent underlying cognitive meaning structures, and the profile of thoughts in a depressed individual tends towards negative appraisals (e.g. Barton & Morley, 1999). Statements of cognitive change, indicating less negative appraisals, have been found to precede disproportionately large symptom improvement between sessions (defined as improvement of 7 or more points on the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock & Erbaugh, 1961) in CT for depression (Tang & DeRubeis, 1999). These large between session improvements, termed 'sudden gains', have been found to be related to better long-term outcome.

Empirical studies have suggested equivocal findings on the role of cognitive change in therapeutic progress in CB and PI therapy. As the focus of CB is on the modification of cognitions, it would be expected that CB therapy would be associated with a greater reduction in such negative appraisals (studied here through negative self-statements) compared to PI therapy, which facilitates change through exploration of emotions. In an early study in which CB therapy sessions were alternated with more exploratory therapy sessions, Teasdale & Fennell (1982) found that the CB sessions produced more cognitive change in depressogenic thoughts than the exploratory sessions did, although the exploratory sessions were not based in any particular theory. On the other hand, Persons & Miranda

(1995) cited evidence that cognitive change did not necessarily underlie therapeutic change in CT, or that cognitive change was unimportant for change in other forms of therapy.

It is unclear therefore how cognitive change is related to change in very brief CB or PI therapy, in particular through 'sudden gains' on the Assimilation model.

1.3 "2+1" therapy.

Within the context of the 'equivalence paradox' i.e. that different psychotherapeutic approaches are equally effective (Stiles et al., 1986), process research has revealed that there are differences in certain factors between CB and PI therapy as discussed above, although it is unclear how these factors may influence outcome. These findings need to be investigated in more detail, and, to increase generalisability need to be applied across different therapy structures. One structure providing material suitable for analysis in the current project was "2+1" therapy from the Sheffield Psychotherapy Project (Barkham, Shapiro, Hardy & Rees, 1999).

2+1 therapy was developed in a research context in an aim to address the needs of individuals with "neurotic" disorders who were not being treated by services seeing those with more severe and enduring problems. In addition to service pressure, 2+1 was also developed as research had shown that almost half of symptom improvement occurs within the first 4

sessions (Howard, Kopta, Krause & Orlinsky , 1986), indicating that short format therapy may harness a large portion of change. Barkham et al. (1999) were interested in examining the feasibility of this very brief form of therapy.

The 2+1 format comprises two 1-hour sessions a week apart followed by a 1-hour session 3 months later. It was hypothesised that symptomatic gains would be made in the early sessions with a follow-up incorporating any changes made due to time. Clients were referred, either by themselves or by their GP, for low mood or depression which was affecting their work. They were randomised to either manualised CB or PI therapy. The former was based on Beck's cognitive-behavioural framework (Beck et al., 1979) although somewhat more behavioural, and included anxiety control training, self-management strategies and cognitive restructuring. PI therapy was based on a conversational model in which a mutual language of feelings was developed to understand the difficulties (Hobson, 1985). The PI model also adopted psychodynamic, experiential and interpersonal concepts to work through the therapist-client relationship (Barkham et al., 1999). Both CB and PI 2+1 therapy were shown to be effective for both subclinical and depressed clients, with approximately two-thirds of clients showing clinically significant change after the three sessions. These gains were maintained at 1-year follow-up, CB showing better maintenance than PI on the BDI (Barkham et al., 1999).

The mechanism of change in 2+1 however is unclear. It is possible that the brief format taps into a phase of "remoralisation" (Howard, Lueger, Maling & Martinovich, 1993) in which the common factors of positive expectations and the therapeutic relationship encourage symptom improvement. In contrast, Barkham et al. (1999) suggested that as 2+1 therapy was highly focused, the different techniques used in CB and PI therapy were more acute, and led to change through theoretically consistent mechanisms. They recommended that process-outcome research be carried out on the 2+1 data to explore the factors contributing to change in CB and PI therapy. Although limited in generalisability by its unique format, length and very specific focus, 2+1 therapy provides a manageable opportunity to study changes in therapist focus, emotional experiencing and cognitive change over a course of therapy for a number of individuals.

1.4 The Assimilation model.

The linking of process and outcome research has been found to be a fruitful one (Llewelyn & Hardy, 2000). However, the psychotherapeutic process is inherently complex and selecting an appropriate outcome measure which is able to reflect change in each process factor is difficult. Linking process to outcome is particularly difficult when long periods of time elapse between the actual in-session experiences and the measuring of outcome (Stiles et al., 1986). Using overall psychometric measurement over a number of sessions as outcome indicators is of limited utility for very brief psychotherapy as there are fewer time points, although the final outcome of BDI scores does provides an indication of symptomatology pre

and post therapy. 'Immediate outcome' measures can reveal within session change and are therefore valuable in allowing events in sessions to be immediately linked to outcome (Greenberg, 1986).

The Assimilation model (Stiles et al., 1990) has been recommended as an appropriate measure of short-term, in-session psychotherapy outcome (Stiles et al., 1991). The Assimilation model proposes that emotional distress is associated with the avoidance and denial of difficult experiences (a memory, feeling, wish, idea or attitude which is experienced as threatening or painful). The greater the discrepancy between the difficult experience and an individual's schema (which can be thought of as a frame of reference, narrative, philosophy, theory or script), the less likely it is that the problematic experience will be assimilated into the schema. The problematic experience is unassimilated due to the person avoiding activating the material, and hence the difficulties remain unresolved leaving the person symptomatic (Stiles et al., 1990). However, problematic experiences can be assimilated to existing schemas through a systematic series of stages of describing and formulating life experiences, leading to a reduction in emotional distress. In successful therapy the problematic experience is gradually assimilated through the modification of existing schema, allowing the development of explanations and associations through which the experience can be understood.

The Assimilation model is a pan-theoretical model, describing the human process of change rather than any specific therapeutic orientation. A

measurement scheme was developed, the Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991) by which to map an individual's pathway through the assimilation stages (a summary of which is in Appendix 1). The first four stages tend to be associated with negative emotion as the client becomes aware of their difficulties. After an 'aha' experience at stage 4 (termed 'understanding/insight'), emotions become more positive as understanding and strategies for coping emerge. By the final stage of mastery, clients achieve a neutral emotional standpoint, as all behavioural, cognitive and emotional factors are integrated into normal functioning (Stiles et al.,1990; Hardy et al.,1998). Psychotherapy assists in assimilation by encouraging acceptance and clear formulation of the problematic experience while also managing the emotional impact.

The outcome of therapy has been found to relate to assimilation level. Honos-Webb, Stiles, Greenberg & Goldman (1998) found that a successful case of process-experiential therapy achieved level 4 while an unsuccessful case terminated therapy when at level 1 or 2, when negative emotion was highest. In 2+1 therapy, successful CB and PI cases were also characterised by reaching level 4 while unsuccessful cases showed less progression on assimilation (Detert, 2000). The assimilation profile for eight clients receiving CB and PI 2+1 therapy will be used as a within session immediate outcome measure by which to relate the factors of therapist focus, clients' experiencing and cognitive change (see Method section).

In summary, process research has identified a number of factors present in psychotherapy. The current research aims to test the broad hypothesis that CB and PI therapy operate through theoretically distinct pathways, and that these pathways have differential effects on both immediate and overall outcome. Three factors – therapist focus, emotional experiencing and cognitive change – have been selected for study, and will be applied to movement through the Assimilation model.

1.5 Hypotheses.

Therapist focus.

1i. The therapeutic focus differs between CB and PI therapists in 2+1 therapy (Blagys & Hilsenroth, 2000). PI therapists will score higher on the 'Constructing Meaning' Scale (which includes self-evaluation, thought, intention, intrapersonal and interpersonal links, and past categories). CB therapists will score higher on the 'Facilitating Action' scale (which includes situation, expectation, actions, current and future scales) (Samoilov et al., 2000).

1ii. Therapist focus is related to assimilation as an immediate outcome within both CB and PI therapy

1iii. Therapist focus differs over the course of therapy.

Experiencing.

2i. There is a higher level of experiencing for clients receiving PI therapy compared to clients receiving CB therapy.

2ii. Significant portions of sessions – defined as movement up 1 or more levels on the Assimilation scale – will show higher experiencing levels in PI therapy but not in CB therapy, when compared to non-significant portions of the sessions – defined as no movement on the Assimilation scale.

2iii. Experiencing scores differ over the course of therapy.

Cognitive change.

3.i The percentage of negative self-statements will show a stronger relationship with excerpt order in CB than in PI therapy.

3ii. Sudden changes in assimilation (defined as 2 or more levels up) are associated with a decrease in negative self-referential statements in CB but not PI therapy.

1.6 Aims.

Overall, the above hypotheses were developed from previous research to explore the mechanisms of change in very brief CB and PI therapy. While both types of therapy have demonstrated equal effectiveness in treating clients with depression, it is unclear whether they do so through common pathways or by adopting equally effective but different pathways. Through exploring the occurrence and level of therapist focus, client experiencing and cognitive change, it was proposed that differences between both forms of therapy would be found. It was also hypothesised that this proposed difference in process would influence outcome in different ways over CB and PI therapy.

2. Method.

The current research adopted a similar approach to Detert (2000) in carrying out an intensive analysis of eight clients receiving 2+1 therapy. Four clients received CB therapy and four received PI therapy, half of each showing good and poor outcome. The study analysed ten selected excerpts from transcripts of therapy for each client.

2.1Clients.

Transcripts from eight clients were available for study. All clients had a BDI score at screening of between 16-25, placing them in the mild-moderate depression range (Beck et al., 1961). The eight clients had been randomly allocated to CB or PI therapy in the 2+1 research trial (Barkham et al., 1999). Of the eight clients studied here, four received CB and four received PI therapy. Two clients from CB and PI were classified as receiving 'good' outcome therapy as they showed significant improvement on the BDI, scoring 2 or less between the second and third session. The remaining two clients receiving CB and PI therapy were classified as 'poor' outcome as they demonstrated little or no improvement on the BDI during this time.

All transcripts were of the first two sessions of 'active' therapy, the third session of the 2+1 format being a follow-up 3 months later. From a previous research project (Detert, 2000), two independent raters had selected ten excerpts from transcripts for each client. These ten excerpts were selected

using an iterative process of reading the transcripts to identify salient themes in the clients' presenting difficulties, then going on to select excerpts of the session which strongly illustrated these themes (Detert, 2000). Client and therapist reports obtained during the therapy were also used to highlight the themes for each client. The excerpts were also selected as they clearly illustrated the clients' internal conflicts as conceptualised using the 'Voices formulation' of "underdog" (i.e. non-dominant) versus "top dog " (i.e. dominant) voices in the clients' speech, according to a manual (Honos-Webb & Stiles 1998). These excerpts were therefore considered to represent significant portions of therapy which focused on the central issue for the client according to their individual formulation. These ten excerpts were regarded as "critical" and "decisive" points in therapy (Hill, 1990), providing manageable amount of data for raters. Assimilation scores for each excerpt had been obtained (Detert, 2000). The median rating of assimilation scores for each of the 10 excerpts per client are presented in Appendix 2.

2.2 Design.

The eight cases provided a balanced block design of therapeutic approach and outcome. The 10 excerpts from each case provided 80 data points which could be compared by therapy mode and outcome. The BDI scores provided an overall outcome measure while the assimilation data previously obtained served as a within session outcome measure.

2.3 Raters.

Raters were recruited through advertisements and personal contacts. The training schemes were learnt by the researcher who then trained the raters. Three raters, the researcher and two assistant psychologists, were trained in the Experiencing scale. At this point, the researcher was blind to therapeutic orientation and outcome of the research cases. Three raters, all third-year trainee clinical psychologists, were trained in the TFAI. Two raters, one second-year trainee clinical psychologist and one assistant psychologist, were trained on the cognitive change coding scheme. All raters were blind to therapy mode and outcome throughout the rating procedure.

2.4 Measures.

2.4.1 The Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991).

The APES is a pan-theoretical measure of clients' assimilation of problematic experiences to existing schemas. Assimilation profiles for each of the eight clients in this study were previously obtained using the APES as rated by four independent raters (Detert, 2000).

2.4.2 Therapeutic Focus on Action and Insight (TFAI; Samoilov et al., 2000)

The TFAI was developed from the Coding Scheme of Therapist Focus (Goldfried, Newman & Hayes, 1989) as an abbreviated version designed

for smaller scale research. The TFAI classifies the focus of a therapist's intervention through coding of therapist utterances. Twelve categories, described in Appendix 3, are scored as present or absent once per therapist turn. Samoilov et al. (2000) found that two scales emerged from the 12 coding categories, Constructing Meaning (CM) and Facilitating Action (FA). The scales had good inter-rater reliability, and moderate construct validity. The TFAI was developed for use by raters with limited clinical experience.

2.4.3 Experiencing Scale (EXP; Klein et al., 1969)

The EXP scale measures clients' emotional involvement in the examination of personal issues through the quality of their participation in therapy. Each patient utterance is rated according to the 7-point scale which develops from 'impersonal' (stage 1) through to increased awareness in stage 7 (Appendix 4). Each patient utterance is rated with modal (most frequently occurring experiencing level of the segment) and peak rating (the highest level reached in the segment). The EXP scale has been used in a number of studies of psychotherapy process, with inter-rater reliabilities ranging from .65 to .93 for mode, and .61 to .93 for peak ratings (Klein et al., 1986). The EXP does not require raters to have significant clinical experience.

2.4.4 Cognitive change.

The procedure for selecting self-statements is described below. Self-statements were coded by raters as either positive, neutral or negative

according to a manual developed from material in Cooper (1990) and Barton (1999). A summary of the categories is presented in Appendix 5. Previous studies using this method of rating showed high inter-rater reliability (91.7% in Cooper, 1992; intra-class correlation=0.86 in Barton, 1999).

2.5 Procedure.

2.5.1 Selecting units of analysis.

Greenberg (1986) recommended that units of analyses for process research should be selected from portions of sessions which were considered to be therapeutically relevant. The 10 excerpts for each client, representing roughly equally both sessions, were thought to represent important points in the course of therapy. These excerpts were then broken down into different units of analyses for rating according to each coding scheme.

Therapist focus.

Coding was made of therapists' turns i.e. therapist utterance which occurred after a client utterance and which was followed by another client utterance. Every therapist turn which included 3 or more words was rated (Samoilov, Goldfried & Greenwalt, 1998). Although the client utterances could be used as context, they were not scored.

Experiencing.

Each client utterance of 3 or more words was coded (Klein et al., 1969).

Cognitive change.

Coding the valency of every client utterance would provide too vast an amount of data for analysis in the current study. It was therefore decided that only self-statements (as opposed to statements including other forms of reference: other, world, past or future, Barton,1999) would be rated as these occur frequently within therapy sessions, and are highly correlated with depression (Barton & Morley, 1999).

Spoken utterances within therapy are of different lengths and contain a widely varying number of propositions. It would therefore be difficult to provide a single valency rating for utterances such as these. Subsequently, self-statements were broken down into more appropriate portions for coding, by dividing the sentences into 'idea units' defined as the smallest possible units which retain the intention and meaning of the speakers utterance (Davison, Robins & Johnson, 1983).

Excerpts for all cases were examined by the researcher for self-statements, before being divided into idea units. In order to ensure that this process was reliable, two cases (i.e. 25% of the whole sample) were also categorised into self-statements and idea units by an independent rater. The proportion of self-statements agreed on by the two raters was 76.4%. In order to calculate how much the independent rater agreed with the researcher, the number of self-statements agreed on was divided by the

overall number of self-statements selected by the researcher. This provided a proportion agreement of 93%, indicating that of the self-statements selected by the researcher, the independent rater agreed on 93%, but also selected additional self-statements which provided the reduced reliability measure of 76.4%. Use of the above formula for idea units (defined as agreement of end-boundaries; Davison et al.,1983), provided percentage agreements of 75.2% and 83.5% respectively. These figures suggested sufficient reliability and the researcher completed coding of the remaining six cases.

The unit of analysis for coding of valency was therefore idea units within self-statements.

2.6 Rating procedure.

2.6.1 Training.

Raters were trained in the use of the three coding schemes by the researcher. Training took between 10 - 15 hours for each coding scheme, using material provided by the experiencing training manual (Klein et al., 1969) and practice therapy transcripts made available from a previous study (Stiles 2000, unpublished material). The majority of training was carried out in rater groups, although some training with the valency manual was carried out individually for practical reasons. Training was evaluated through comparison with manuals (experiencing; cognitive

change) or through personal e-mail communication with the authors of the manual (therapist focus).

2.6.2 Rating.

Following training, coding of the experimental transcripts was carried out, with each rater coding every case. Rating was done either individually or as a group, depending on raters' preferences. The ten excerpts from each case were placed in a random sequence in order to minimise raters developing their own narrative of the therapy. The order of excerpts remained uniform across the three coding schemes.

2.7 Inter-rater reliability.

Inter-rater reliability was calculated using the Intraclass Correlation Coefficient (ICC; Shrout & Fleiss,1977). The 2-way random formula was used as the raters were regarded as a random sample of judges selected from a larger population, with each judge rating each target (i.e. Case 2). The ICC provides an estimated reliability for single raters (ICC=1,1) and mean of K raters (ICC=1,k).

2.7.1 Rater drift.

In an aim to reduce rater drift, excerpts from two cases only were initially rated. Inter-rater reliabilities for these two cases were calculated and fed-back to the group of raters before completing the remaining transcripts. If

there were significant discrepancies in rating styles, the coding scheme was reviewed and discussed.

For the experiencing scale, the ICC indicated adequate reliability, taking Goldfried et al.'s (1997) criteria of ICC=.5 as the margin of acceptability. The ICC values for the experiencing scale are presented in Table 1.

Table 1: Single rater and mean of raters ICC values for experiencing scores for the first two cases.

	Single rater ICC	Mean of raters ICC
Mode experiencing scores	.4039**	.6702**
Peak experiencing scores	.4579***	.7171***

Key: ** p<.01, ***p<.001

Separate ICC analyses were carried out for each of the 12 categories of the TFAI in order to prevent over collapsing of the data which could lead to inaccurate ICC scores (Watson 2002, personal communication). These revealed single rater ICC values of between .2355 and .7494 (all p<.001) and mean of raters ICC values of between .4803 and .8997 (all p<.001). Some ICC values were very small, therefore rater discrepancies were discussed before continuing to rate the remaining six cases.

Inter-rater reliability for valency of self-statement ratings was calculated using Cohen's Kappa which takes into account agreements between raters

that could occur due to chance. For the first two cases the Kappa analysis indicated an agreement of 52.5%, indicating fair to good agreement (Armitage & Berry1994).

2.7.2 Overall reliability.

The ICC for experiencing and TFAI ratings for all cases are presented in Table 2. Although a number of the TFAI categories indicated very low ICC values (e.g. ICC (1,3)= .2855 for the 'thought' category), it was considered appropriate to retain them in further analyses as this was an exploratory study. Also, the categories were components of two 'umbrella' scales, FA and CM, and it was necessary to retain every category for scale cohesion. Results involving these categories should nevertheless be interpreted with caution.

Table 2: ICC values for single and mean raters for EXP and TFAI scales.

Coding scheme	No. of raters	ICC estimated reliability Single rater***	Mean of K raters***
EXP:			
Mode	3	.6158	.8279
Peak	3	.7040	.8771
TFAI:			
FA:	3		
Situation		.3274	.5935
Expectation		.4606	.7193
Action		.3520	.6197
Current		.2689	.4238
Future		.5040	.7530
CM:			
Self-eval.	3	.4811	.7356
Thought		.1175	.2855
Intention		.4983	.7488
Emotion		.6772	.8629
Intrapersonal		.4542	.7140
Interpersonal		.6992	.8746
Past		.5569	.7154

*** all ratings presented are significant at p<.001

Inter-rater reliability for valency on all cases as measured by Cohen's Kappa provided a value of overall agreement of 59.8%, placing it in the fair to good agreement range (Armitage & Berry 1994).

2.8 Ethical approval.

Ethical approval for the original research project was obtained by the Northern General Hospital (Sheffield) Ethics Committee in 1986. For the current research, ethical approval was obtained through an internal ethics committee; an ethics form was completed and examined by three clinical psychologists following which amendments were made as necessary before final approval (Appendix 6). Confidentiality agreements from Sheffield University were signed by each rater before starting to rate the experimental transcripts. Names of raters were also sent to the link person in Sheffield.

2.9 Therapist and rater allegiance.

The preferred therapeutic stance of a therapist can have an impact on outcome of treatment (e.g. Robinson, Berman & Neimeyer,1990; Luborsky et al. 1999), showing a positive bias towards the effectiveness of preferred treatment approach in comparative studies. Therapists in the 2+1 study claimed no preference towards either of the treatment approaches (Hardy et al., 1998). Adherence to the manualised treatments were rated as consistently good by independent observers for the three therapists who carried out both PI and CB (Barkham et al., 1999). The current researcher has used both CB and psychodynamic approaches in clinical work

throughout training, and, as a third year trainee currently maintains no strong allegiance towards either approach. Similarly, raters stated no preference or bias towards a single therapeutic mode before rating the transcripts.

3. Results.

3.1 Clients.

Transcripts of the eight clients were obtained from a previous study by Detert (2000). These clients had been involved in the 2+1 Sheffield Psychotherapy Project, recruited to the psychology clinic from self-referrals and GPs and randomly allocated to either CB or PI therapy (Barkham et al., 1999). Detert (2000) selected these clients as they showed roughly equivalent pre-therapy BDI scores and had data at all assessment points. All were white-collar workers experiencing significant difficulties in functioning at work. Table 3 presents descriptive data and the therapy mode to which clients were randomly assigned. Outcome as measured by the BDI is also presented.

Table 3: Descriptive data, therapy mode and BDI scores for each client, indicated by reference number.

Client No.	Sex	Age	Marital status	Therapy mode	BDI at screening	BDI after session 2	Outcome group
110	F	57	Single	CB	18	0	Good
153	M	42	Married	CB	19	1	Good
159	M	51	Married	CB	18	18	Poor
48	F	30	Single	CB	16	19	Poor
140	F	36	Partner	PI	25	0	Good
132	F	22	Single	PI	18	2	Good
150	F	46	Married	PI	17	15	Poor
36	F	49	Married	PI	16	15	Poor

Key: CB=Cognitive Behavioural therapy

PI = Psychodynamic Interpersonal therapy

3.2 Foreword to analyses used.

Parametric analyses are more powerful than non-parametric analyses, particularly for small sample sizes, and they provide the opportunity to explore the interactions between a number of variables. However, parametric tests require that the data conform to criteria of equal variance, normal distribution and interval in nature. In the current research, 80 data points were available for analysis (10 for each client). However, the 80 excerpt points were considered too small, with too high a variability to be sufficiently reliable for use within parametric analyses. From consultation with a statistician, it was suggested that amalgamation of the data, providing one score per client, was a reasonable method by which to provide a more robust composite picture. Although a large amount of specific data may be obscured by this method, it ensures that only those phenomena occurring frequently and to a greater degree will surface, rather than any anomalies of small data points. Having carried out this amalgamation, comparison of largest and smallest unstandardized residual scores for the TFAI and experiencing results on the whole revealed F ratio values indicating acceptable equality of variance for the eight cases. Tests of normality revealed no concern about the distribution of the data. However, it should be recognised that all of these analyses were carried out on the basis of only eight data points. Nevertheless it was considered appropriate to carry out parametric tests on the following hypotheses, in particular ANOVA's and T-tests which are sufficiently robust to deal with

small sample sizes and any moderate violations of the above assumptions (Armitage & Berry, 1994).

In analyses of cognitive change, and in order to compare the current data with the assimilation data from a previous study, it was necessary to use the 80 data points. As stated above, tests revealed that the 80 data points were less able to conform to the assumptions of equal variance and normal distribution. Therefore non-parametric tests were carried out. It was not possible to look at the interactional effects between variables using these methods, nevertheless it was felt that using non-parametric tests would be preferable to using parametric analyses with unsuitable data.

3.3 The Assimilation scale.

As described previously, assimilation data from a previous research study (Detert, 2000) was used as a within-session outcome measure. The Assimilation model is a stage model with movement up to level 4 ("understanding/insight") indicating an increasing awareness and insight into the difficulties. Assimilation beyond level 4 is characterised by working through the difficulties in order to eventually reach the final stage of "mastery". The theoretical predictions arising from the Assimilation model therefore differ in the stages occurring up to level 4 and those occurring after. In order to remain theoretically consistent, it was necessary to differentiate assimilation movement up to and including level 4 from movement taking place at level 5 upwards. Detert (2000)

demonstrated that for these eight clients there were only three data points at which assimilation went beyond level 4 (to levels 5 and 6). It would not have been feasible to carry out assimilation analyses on just three data points. Therefore, these were removed allowing analyses with the remaining 77 data points. Similarly, when exploring 'significant' and 'sudden' change portions, these three data points were removed as the predictions would be different for those gains made above level 4 and those below level 4.

3.4 Hypothesis testing.

3.4.1 Therapist focus (TFAI).

TFAI ratings were carried out on 251 therapist utterances in total over the eight cases. The procedure by which CM and FA scores were obtained, based on Goldfried et al.'s (1997) method, was complex therefore a worked example is presented in Appendix 7. The overall percentage Constructing Meaning (CM; self-evaluation, thought, intention, emotion, intrapersonal, interpersonal, past) and Facilitating Action (FA; situation, expectation, action, current, future) scores for each client are presented in Table 4. As the TFAI measures the strength of the focus rather than just its presence or absence, the values in the table represent the degree of focus on CM and FA through percentages. These values come from independent categories and therefore do not add up to 100%.

Table 4: Percentage of utterances rated as having CM and FA categories present for each client, and totals for CB and PI therapy.

	% of CM rated present	% of FA rated present
110 – good CB	23.4	26.7
153 – good CB	30.3	32.0
159 – poor CB	31.2	28.7
48 – poor CB	30.6	21.9
Total mean CB	**28.9**	**25.7**
132 – good PI	39.8	25.0
140 – good PI	40.9	22.7
150 – poor PI	32.4	25.3
36 – poor PI	34.1	27.8
Total mean PI	**37.1**	**25.4**

Key: CB=Cognitive Behavioural therapy PI = Psychodynamic Interpersonal therapy

CM=Constructing Meaning FA = Facilitating Action

In order to illustrate the discussions in therapy represented in the figures above, transcripts of excerpts with the highest CM and FA scores are presented in Appendix 8.

Hypothesis 1i: PI therapists will score higher on the CM scale and CB therapists will score higher on the FA scale.

Table 4 shows that PI therapists had a higher CM score than CB therapists. As discussed above, data for the eight cases were suitable for parametric analyses, which while being more powerful than non-parametric analyses, also provide the opportunity to explore interactions between the factors which was of interest here. A 2-way ANOVA (therapy x outcome) of the total CM scores for the eight cases showed that there was a significant difference between CB and PI ($F=19.29$, $d.f.=1,4$, $p<.05$). There was also a main effect of outcome ($F=9.55$, $d.f. = 1,4$, $p<.05$). The above table would

suggest that good PI had significantly higher CM scores than poor PI and good CB had significantly lower CM scores than poor CB.

A 2-way ANOVA (therapy x outcome) of total FA scores over the 8 cases revealed no main effects of outcome, therapy mode or interaction.

Hypothesis 1ii: Therapist focus is related to assimilation as an immediate outcome within both CB and PI therapy.

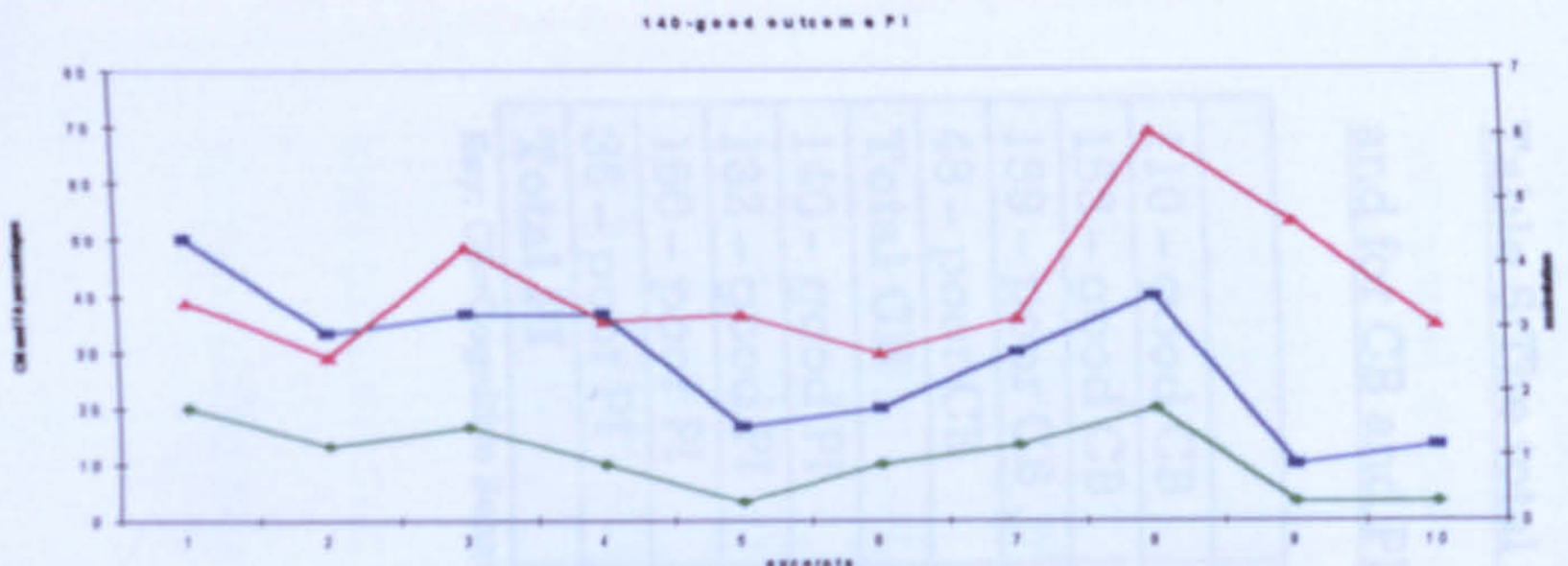
The non-parametric equivalent of Pearson's correlation coefficient, Spearman's rho, was used to test whether CM and FA scores for each excerpt were related to assimilation scores for each excerpt. No significant correlation was found between CM or FA scores and assimilation scores either as a whole, or by therapy mode and outcome. CM and FA scores also showed no significant correlation with assimilation scores when taken case by case.

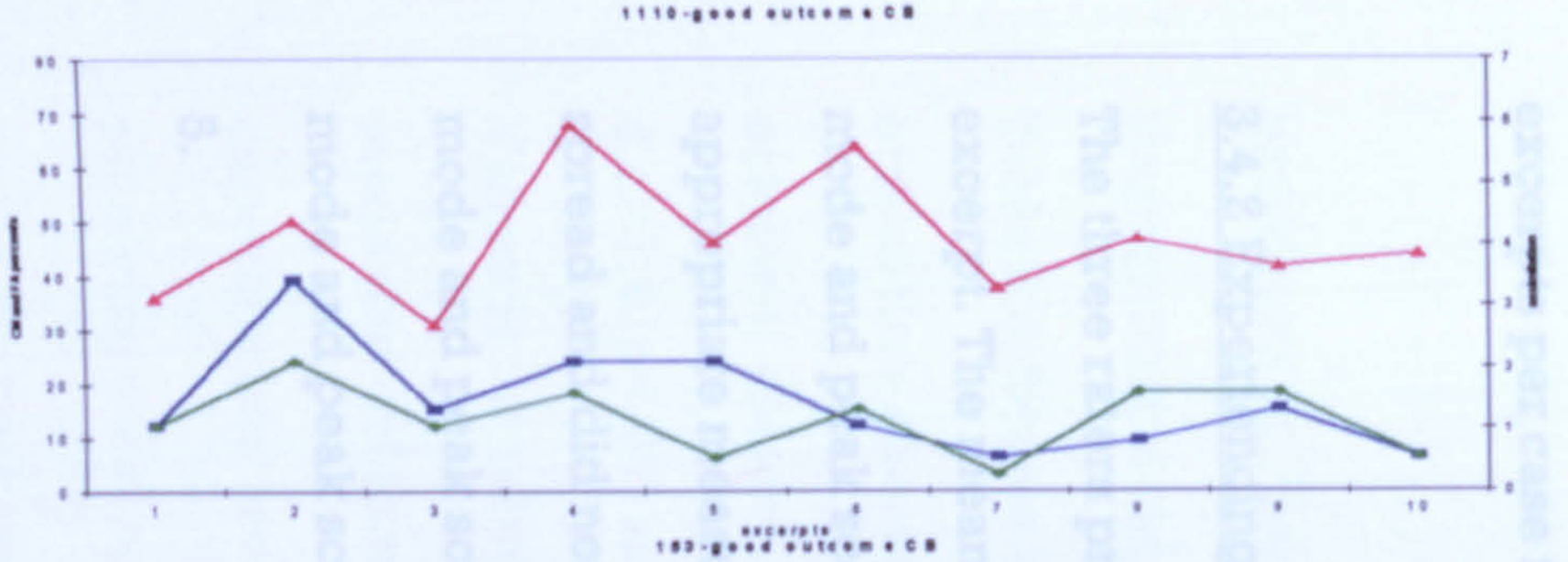
CM and FA scores and assimilation scores are presented graphically in Figure 1.

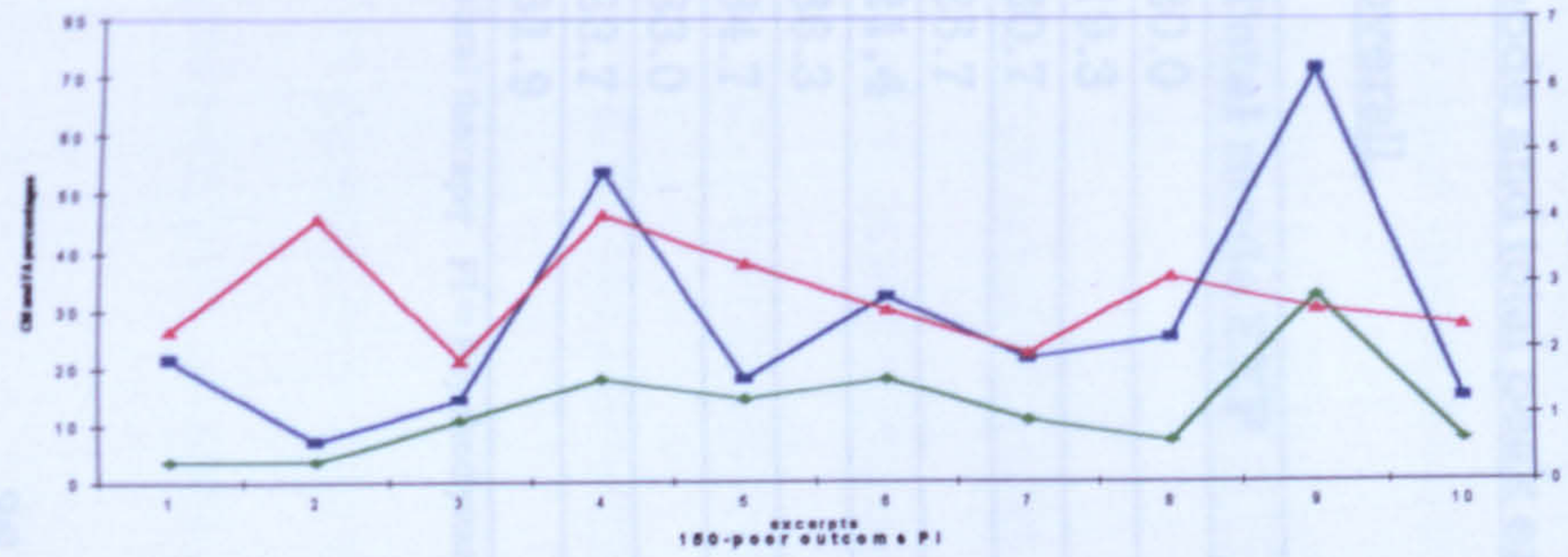
Hypothesis 1iii: Therapist focus differs over the course of therapy.

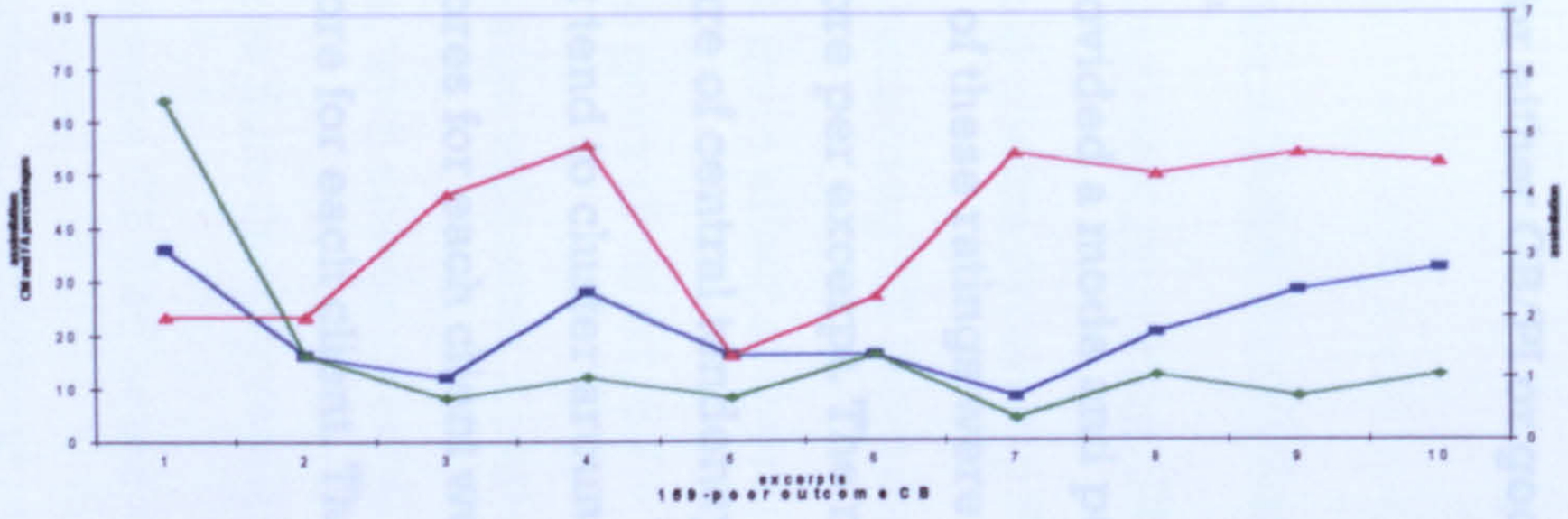
In order to test change in therapist focus over time, Kendall's tau was used to correlate CM and FA scores with excerpt order. As the excerpts were not uniformly spaced in time, making the data ordinal in nature, a non-parametric test such as Kendall's tau was considered appropriate. Kendall's was also chosen as it was designed for use with data containing

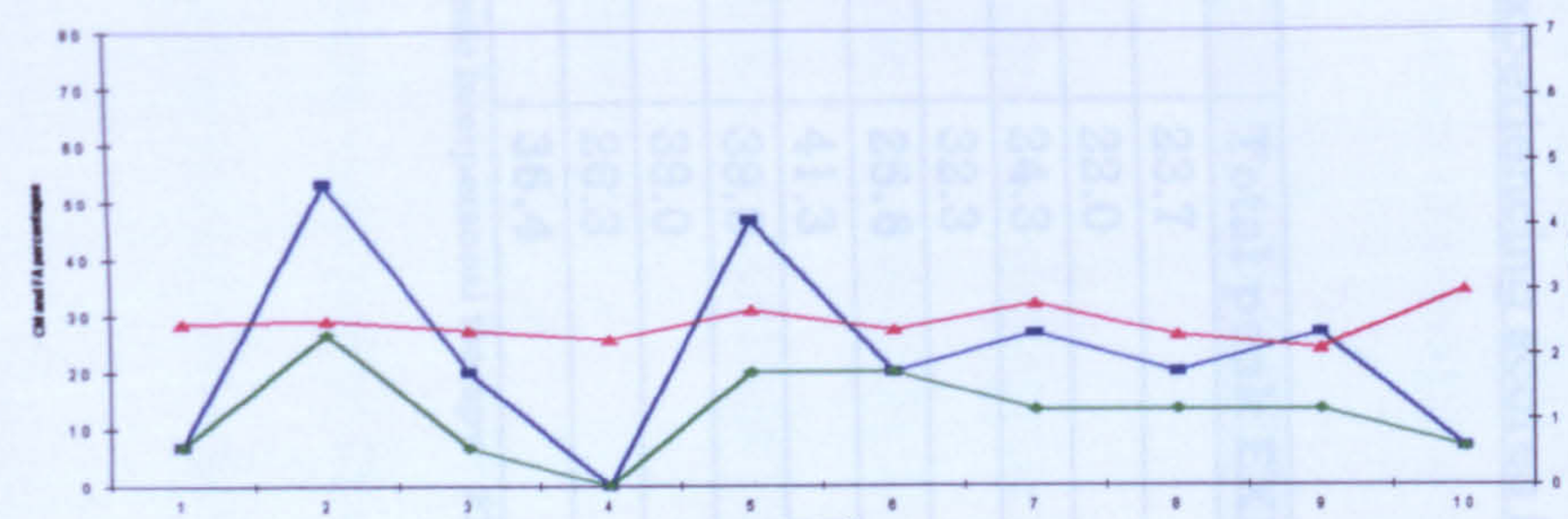
Figure 1: Graphs of assimilation score and percentage CM and FA totals per excerpts per case KEY: Assimilation, CM, FA

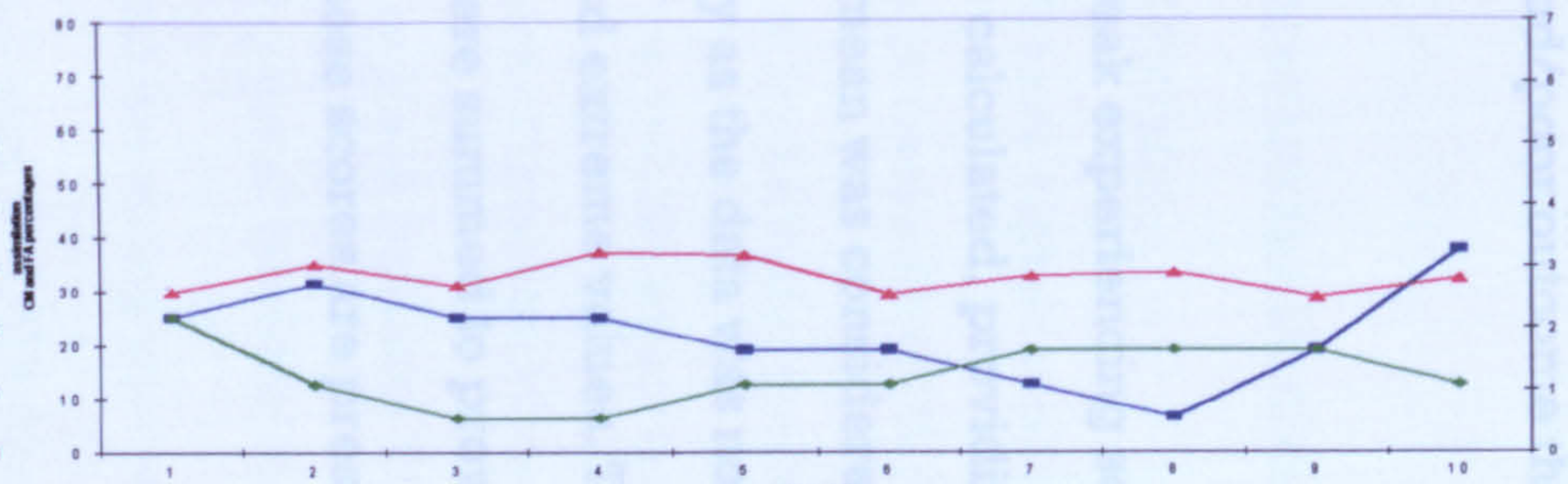


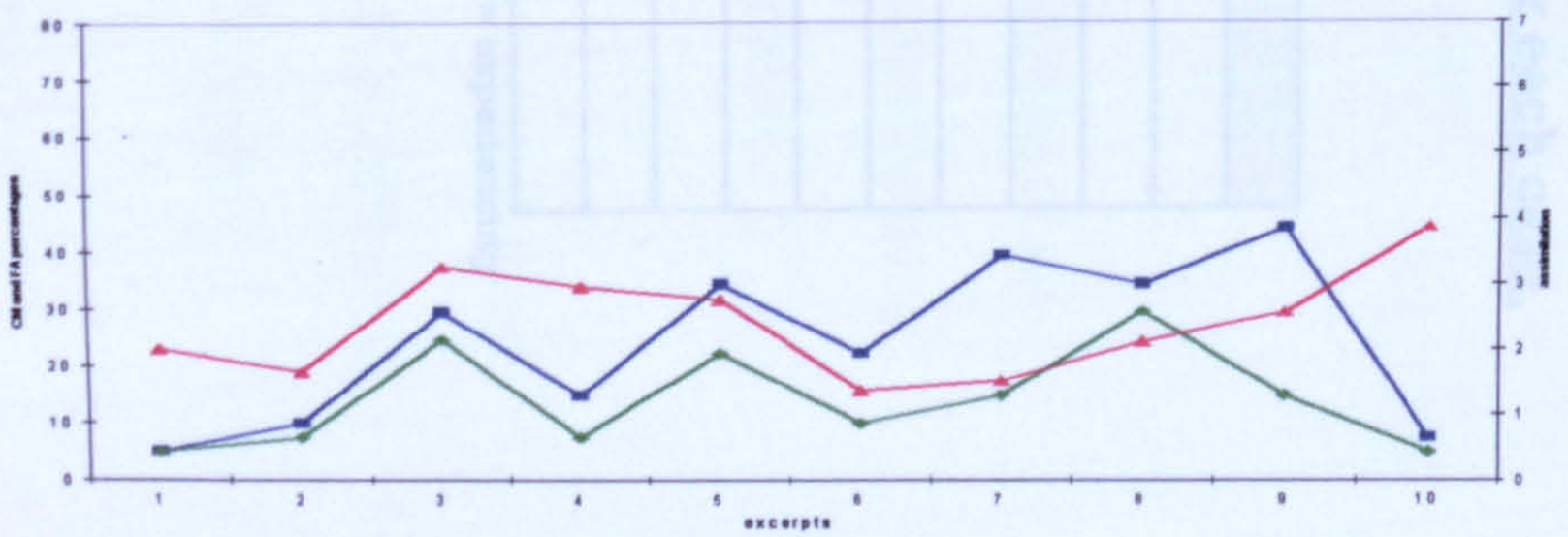


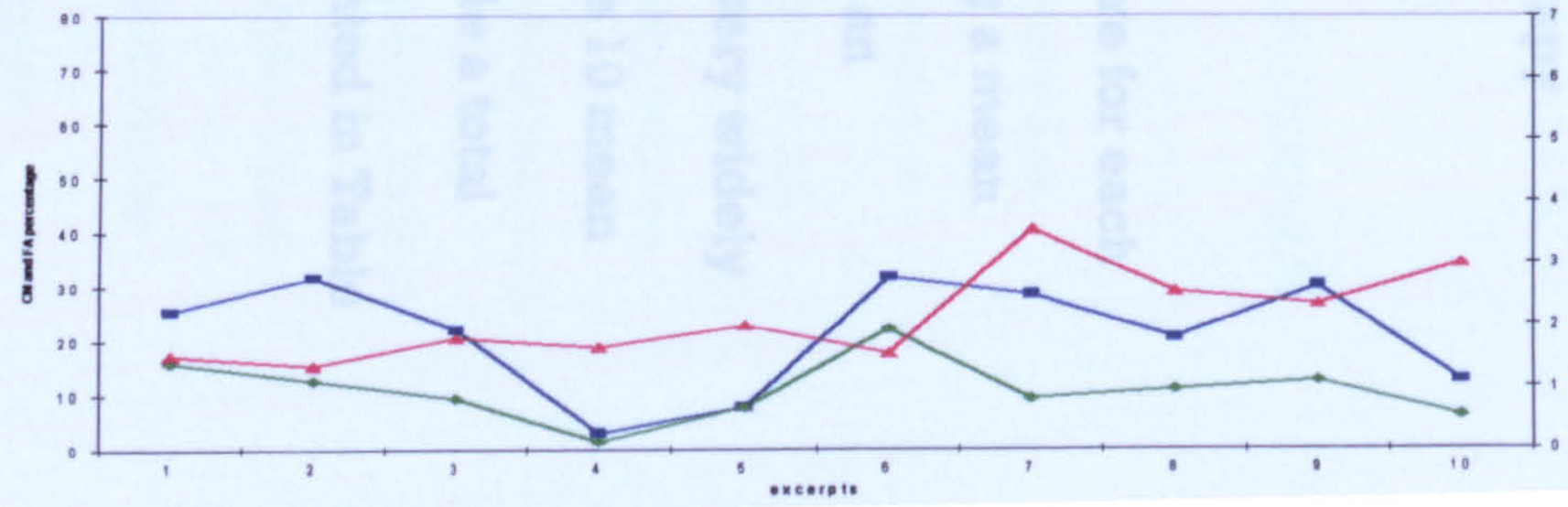












tied values, many of which would be expected in this data. Analyses revealed no significant differences in CM and FA scores over the 10 excerpts per case for either CB/PI or good/poor outcome therapy.

3.4.2 Experiencing.

The three raters provided a mode and peak experiencing score for each excerpt. The mean of these ratings were calculated, providing a mean mode and peak score per excerpt. The mean was considered an appropriate measure of central tendency as the data was not very widely spread and did not tend to cluster around extreme values. The 10 mean mode and peak scores for each client were summed to provide a total mode and peak score for each client. These scores are presented in Table 5.

Table 5:The total mode and total peak experiencing scores for each case, and for CB and PI overall.

	Total mode EXP	**Total peak EXP**
110 – good CB	20.0	23.7
153 – good CB	19.3	22.0
159 – poor CB	20.7	24.3
48 – poor CB	25.7	32.3
Total CB	**21.4**	**25.6**
140 – good PI	36.3	41.3
132 – good PI	34.7	39.0
150 – poor PI	33.0	39.0
36 – poor PI	23.7	26.3
Total PI	**31.9**	**36.4**

Key: CB=Cognitive Behavioural therapy PI = Psychodynamic Interpersonal therapy EXP = experiencing

In order to provide an illustration of experiencing as rated in transcripts of therapy, transcripts of excerpts showing the highest mean mode and peak experiencing ratings in CB and PI therapy are provided in Appendix 9.

Hypothesis 2i: There is a higher level of experiencing for clients receiving PI therapy compared to clients receiving CB therapy.

Table 5 indicates that clients receiving PI have higher mode and peak scores than clients receiving CB therapy. A 2-way ANOVA (therapy x outcome) showed a main effect of therapy for both the mode ($F=15.28$, $d.f.=1,4$, $p<.05$) and peak ($F=8.03$, $d.f.=1,4$, $p<.05$) experiencing scores. Values in the table also indicated a pattern of interaction between therapy mode and outcome, with clients receiving good outcome PI having higher experiencing scores than those receiving poor outcome PI, while clients receiving good outcome CB had lower experiencing scores than those receiving poor outcome CB. However, a 2-way ANOVA (therapy x outcome) showed no main interactional effect of therapy mode and outcome on mode or peak experiencing scores.

Hypothesis 2ii: Significant portions of the sessions-defined as movement up one or more levels on the assimilation scale – will show higher experiencing levels in PI but not in CB, when compared to non-significant portions - defined as no movement on the assimilation scale.

An initial test of correlation between experiencing scores and assimilation was carried out. Non-parametric tests were used as the 80 data points were required for this analysis, and, as stated previously this data did not

conform to the requirements for a parametric test. Values for 2-tailed significance are quoted as there was no clear prediction of directionality for this initial test. The four PI cases showed a significant correlation between both mode and peak experiencing scores and assimilation ($r=.404$, $p<.05$ and $r=.415$, $p<.01$, respectively). For the CB cases, correlations for experiencing and assimilation scores showed negative r-values but were not significant.

'Significant' portions of sessions were defined as movement up 1 or more levels on the assimilation scale between excerpts (consequently there was no data for the first excerpt for each case as it was not possible to calculate a differential score from the previous excerpt). There were 10 significant points over the eight clients, distributed almost equally over CB (four 'significant' portions) and PI (six 'significant' portions), with seven of these points occurring in good outcome therapy. Numbers of 'significant' excerpts were therefore very small. As can be seen from Table 6, mean experiencing scores are higher in PI than CB therapy, as found in analyses for the previous hypothesis.

Table 6: The mean mode and peak experiencing scores overall for CB and PI in 'significant' and 'non-significant' excerpts.

		CB	PI
'Significant' excerpts	**Mean of mode EXP scores**	2.0 (s.d.=.0)	3.38 (s.d.=.845)
	Mean of peak EXP scores	2.58 (s.d.=.419)	3.94 (s.d.=.680)
'Non-significant' excerpts	**Mean of mode EXP scores**	2.16 (s.d.=.564)	3.20 (s.d.=1.04)
	Mean of peak EXP scores	2.567 (s.d.=.774)	3.59 (s.d.=1.13)

Key: CB=Cognitive Behavioural therapy PI = Psychodynamic Interpersonal therapy EXP = experiencing

The Kruskal-Wallis test, which uses mean rank values, was used as a non-parametric equivalent of the parametric one-way ANOVA. There was no main effect for mode or peak experiencing scores in 'significant' compared to 'non-significant' portions of the session for either CB or PI, or good and poor outcome therapy.

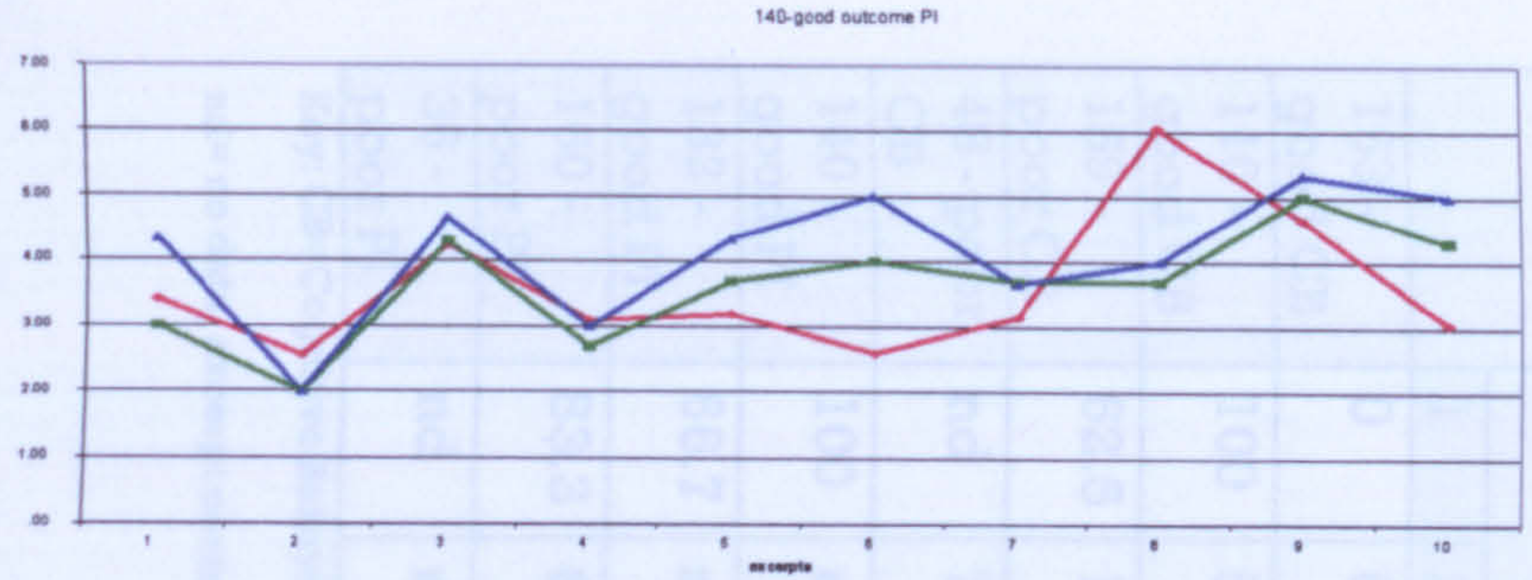
Experiencing scores and assimilation scores for each client are presented graphically in Figure 2.

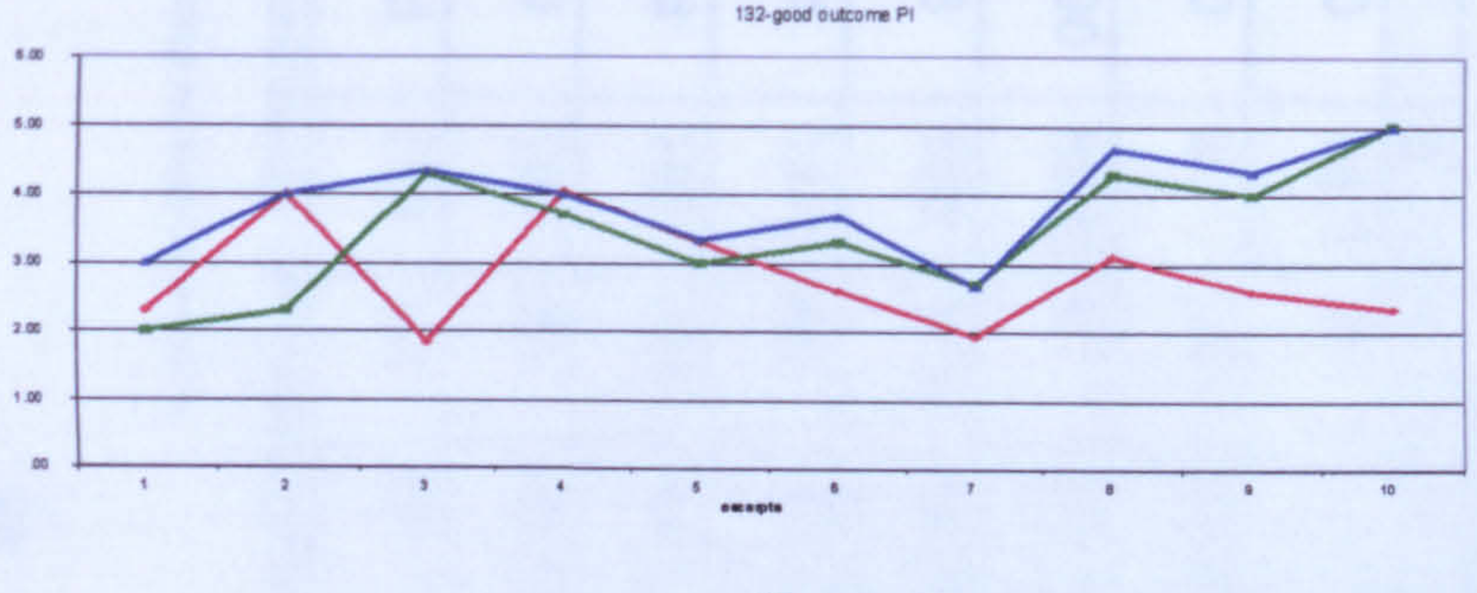
Hypothesis 2iii: Experiencing scores differ over the course of therapy.

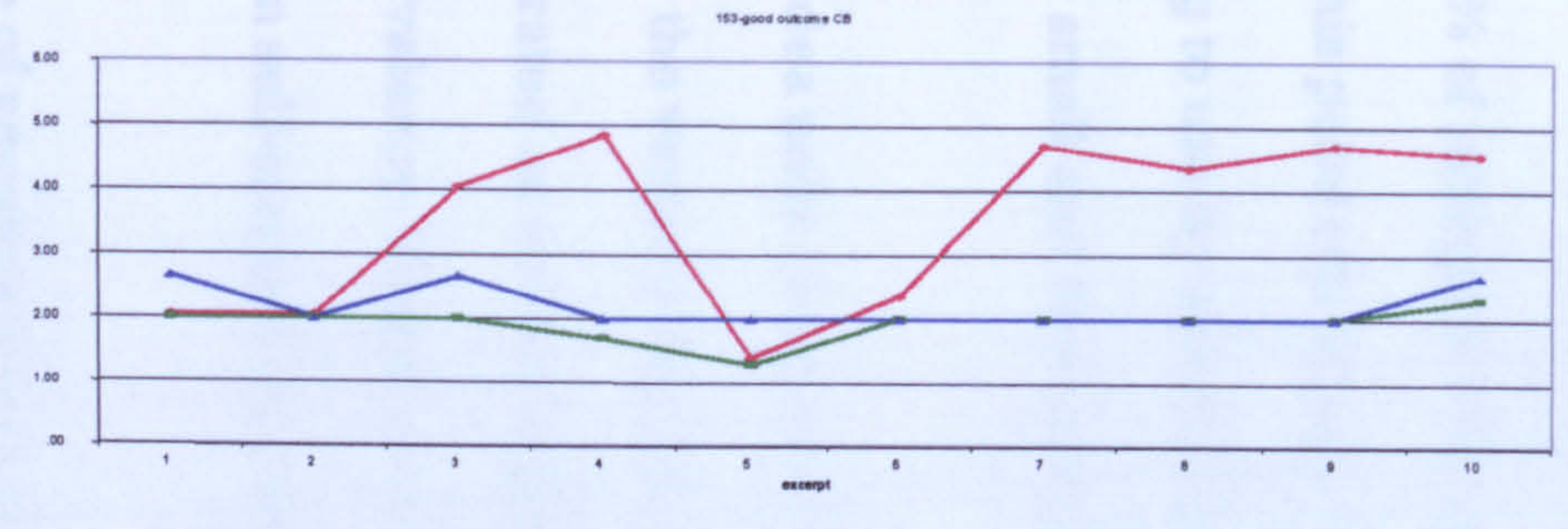
In order to look at whether experiencing level was related to excerpt order, Kendall's tau coefficient was calculated (for reasons stated previously). Analyses used 2-tailed significance levels as there were no clear predictions of directionality, and indicated that both mode and peak experiencing scores were significantly correlated with excerpt order in the two good outcome PI therapy cases (mode tau=.521, $p<.01$; peak tau=.361, $p<.05$). Experiencing scores were not significantly correlated with excerpt order for poor PI cases nor any CB cases. Good outcome CB cases only had negative tau values, indicating an inverse non-significant relationship between mode and peak experiencing scores and excerpt order. No other cases had negative tau values.

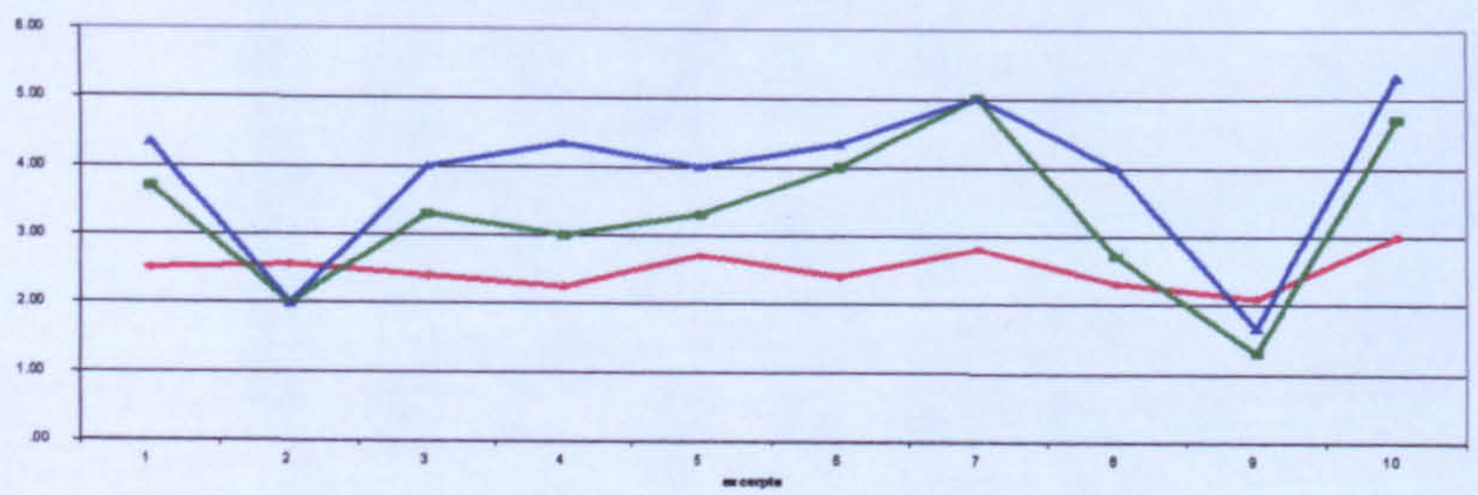
Figure 2: Graphs of assimilation scores and EXP scores per excerpt per case

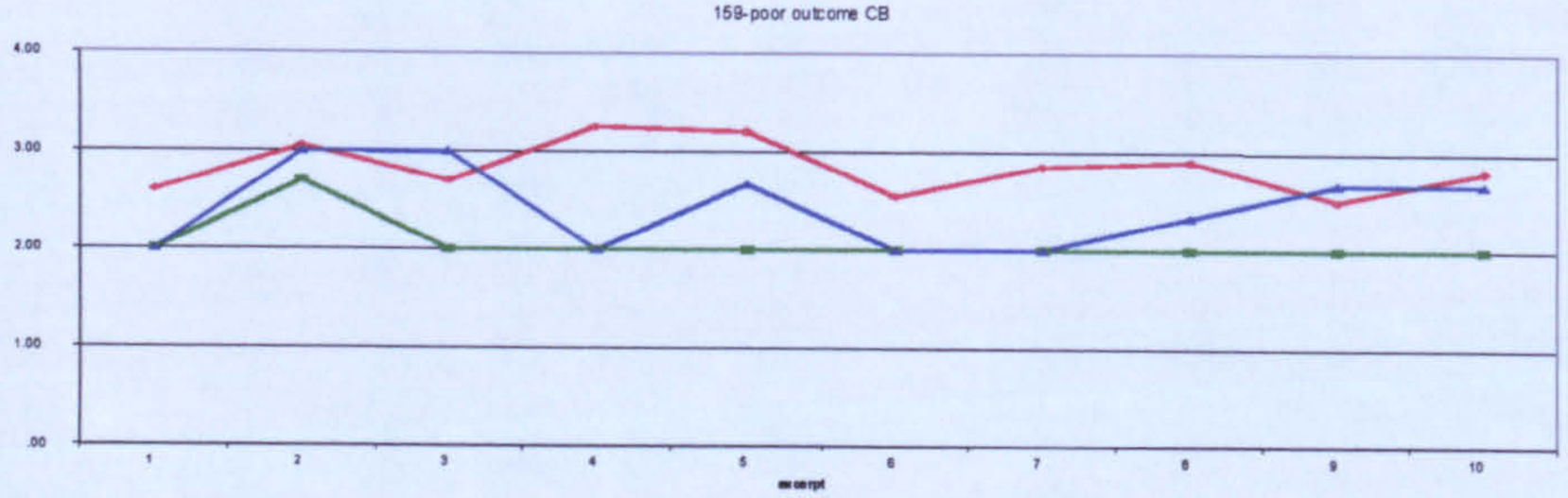
KEY: assimilation, modeEXP, peakEXP

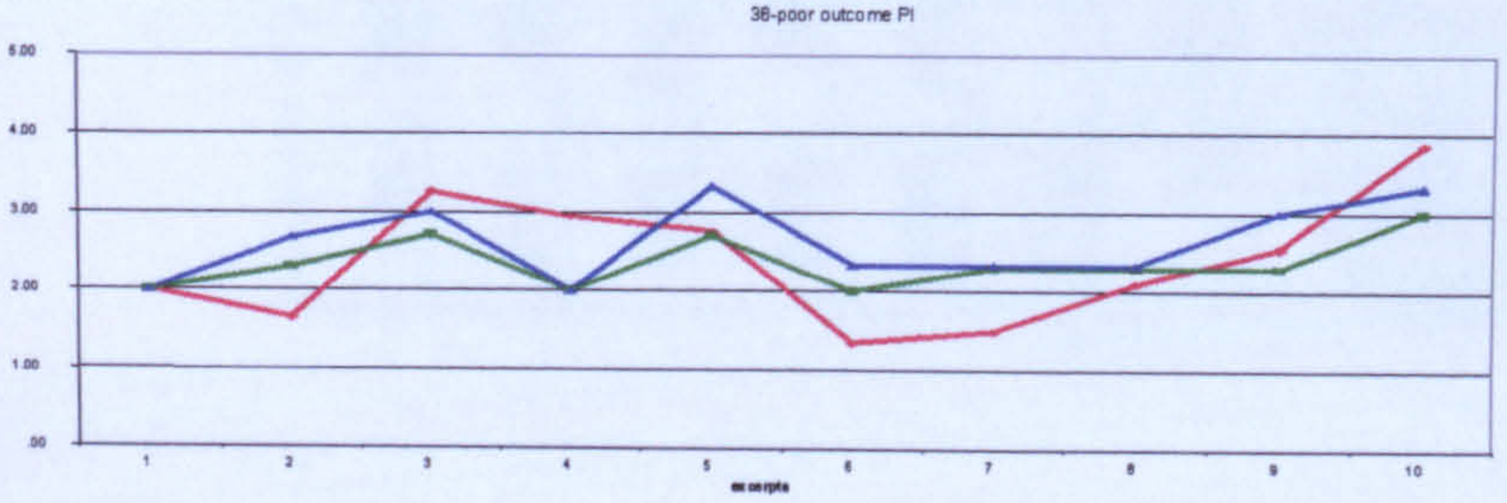


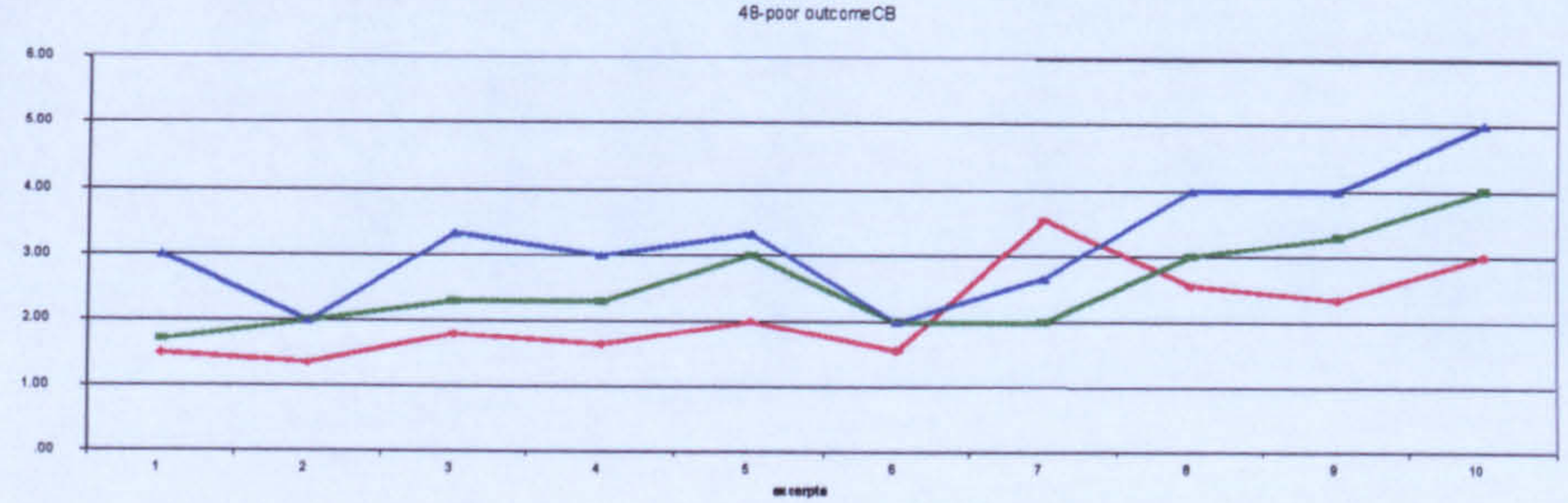












3.4.3 Cognitive change

A total of 336 ratings of idea units of self-statements were obtained over the eight cases. The 22% of ratings (n=74) not agreed upon were examined by the researcher, at this point still blind to outcome and therapy, who chose which raters' coding to use by examining the transcripts. The units of analyses were very small and therefore should be treated with caution.

The percentage of idea units rated as negative was then calculated in order to take into account the varying number of idea units per excerpt. Some excerpts had been rated as not containing any self-statements, therefore were not coded for valency. These are referred to as no data (nd) in the table below. Data on self-statements was available for 63 excerpts.

Table 7: Percentage of negative ideas units per excerpt for each client.

	Excerpt number									
	1	2	3	4	5	6	7	8	9	10
153 - good CB	0	60	16.7	50	nd	nd	0	nd	16.7	30
110 - good CB	100	50	0	nd	83.3	0	0	nd	100	0
159 - poor CB	62.5	100	83.3	0	60	100	87.5	nd	0	85.7
48 - poor CB	nd	75	100	71.4	33.3	75	nd	100	100	28.6
140 - good PI	100	nd	12.5	50	33.3	50	25	50	25	42.8
132 - good PI	66.7	nd	100	100	58.3	83.3	100	100	78.6	66.7
150 - poor PI	83.3	60	100	80	66.7	nd	nd	nd	nd	100
36 - poor PI	nd	nd	100	nd	60	33.3	66.7	60	100	25

Key: CB=Cognitive Behavioural therapy PI = Psychodynamic Interpersonal therapy

nd= no data, excerpt containing no self-statements.

In order to provide examples of utterances showing the above scores, self-statements were selected showing a range of negative ratings, from 100% negative to 0% negative. These are presented in Appendix 10.

Hypothesis 3i: The percentage of negative self-statements will show a stronger relationship with excerpt order in CB than in PI therapy.

Kendall's tau was calculated to compare the percentage of negative self-statement idea units uttered by the client over the 10 excerpts of therapy. There was no significant correlation between valency and excerpt according to therapy mode or outcome, although all tau-values were negative suggesting an inverse non-significant relationship between negative self-statements and excerpt order.

In order to explore whether there were any differences in negative self-statements in therapy type and mode overall rather than over time, mean percentages were calculated. The means percentage of negative self-statements per excerpt are presented in Table 8. Good outcome CB therapy had the lowest percentage of negative self-statements per excerpt, followed by good outcome PI, then poor CB and poor PI cases.

Table 8: Mean percentage negative self-statements per excerpt in good and poor outcome CB and PI therapy.

Outcome	Therapy type	
	CB	**PI**
Good outcome	**33.78%** (n=15) (s.d.=33.68)	**63.46%** (n=18) (s.d.=29.49)
Poor outcome	**68.37%** (n=17) (s.d.=33.78)	**71.92%** (n=13) (s.d.=25.04)

Key: CB=Cognitive Behavioural therapy PI = Psychodynamic Interpersonal therapy

A Mann-Whitney U test indicated no main effect of therapy on negative self-statements in CB and PI therapy but there was a main effect of outcome (U=-2.287, p<.05, 2-tailed). It was not possible to look at the interaction between therapy mode and outcome using non-parametric tests.

Hypothesis 3ii: 'Sudden gains' in assimilation - defined as 2 or more levels up - are associated with a lower percentage of negative self-statements in CB but not PI therapy.

An overall test of correlation between assimilation scores and percentage of negative self-statements was carried out. Spearman' s non-parametric test of correlation indicated that percentage of negative self-statement idea units was significantly correlated with assimilation score in CB cases (r=-.351, p<.05, 2-tailed) but not in PI therapy.

'Sudden gains' were defined as movement up 2 or more levels on the assimilation scale in one excerpt (therefore there was no data on sudden change in the first excerpt as there was no previous excerpt by which to

compare values). The three data points having assimilation scores above level 4 were kept in for this analysis as there is little theoretical support for predictions about this phenomena which is distinct from the more sequential movement along the assimilation stages. There were six such 'sudden gains' over the eight cases, distributed evenly over CB and PI therapy modes. All but one occurred within good outcome therapy. All 'sudden gains' were seen in the second or third excerpt. Ratings of the degree of negative self-statements were available for four of these six 'sudden gains'. Two of these 'sudden gains' occurred in one clients' therapy, case 153 (good outcome CB), the other two occurred in cases 132 (good outcome PI) and 140 (good outcome PI). The mean percentage of negative self-statements for 'sudden' and 'non-sudden' gains excerpts in CB and PI therapy are presented in Table 9. The data comes from one individual only for CB and two individuals for PI. Caution must be applied to analyses using data from so few clients.

Table 9: The mean percentage of negative self-statements in 'sudden gains' as compared to 'non-sudden gains' excerpts of CB and PI therapy.

	CB	PI
	Mean % negative self-statements	Mean % negative self-statements
'Sudden gains' excerpts (n=2 for both CB and PI)	8.35 (s.d.=11.81)	75.0 (s.d.=35.35)
'Non-sudden gains' excerpts (n= 25 for CB; n=22 for PI)	55.18 (s.d.=38.39)	64.51 (s.d.=28.25)

Key: CB=Cognitive Behavioural therapy PI = Psychodynamic Interpersonal therapy

As can be seen from Table 9, the percentage of negative self-statements is lower in 'sudden gains' as compared to 'non-sudden gains' excerpts in CB therapy. However, in PI therapy the mean percentage of negative self-statements is higher in 'sudden gains' excerpts than 'non-sudden gains' excerpts.

The Mann-Whitney U test showed no main effects of therapy on the percentage of negative self-statements in 'sudden gains' compared to 'non-sudden gains' excerpts.

The percentage of negative self-statements and assimilation scores per excerpt for each client are presented graphically in Figure 3. In order to differentiate those excerpts which did not contain any self-statements from those which did contain self-statements but were rated as 0% negative, a figure of 1% has been given to these latter excerpts.

As the number of data points used in the above analysis was small it was possible to study the transcripts in order to gain more of a picture of the process. Therefore, the negative self-statements in the client utterances in excerpts rated as 'sudden gains' are presented in Table 10. The brackets denote the beginning and end boundaries of the idea units. These transcripts are provided for information and are not analysed, but will be referred to in the Discussion section.

Figure 3: Graphs of assimilation score and percentage negative self-statements per excerpt per case

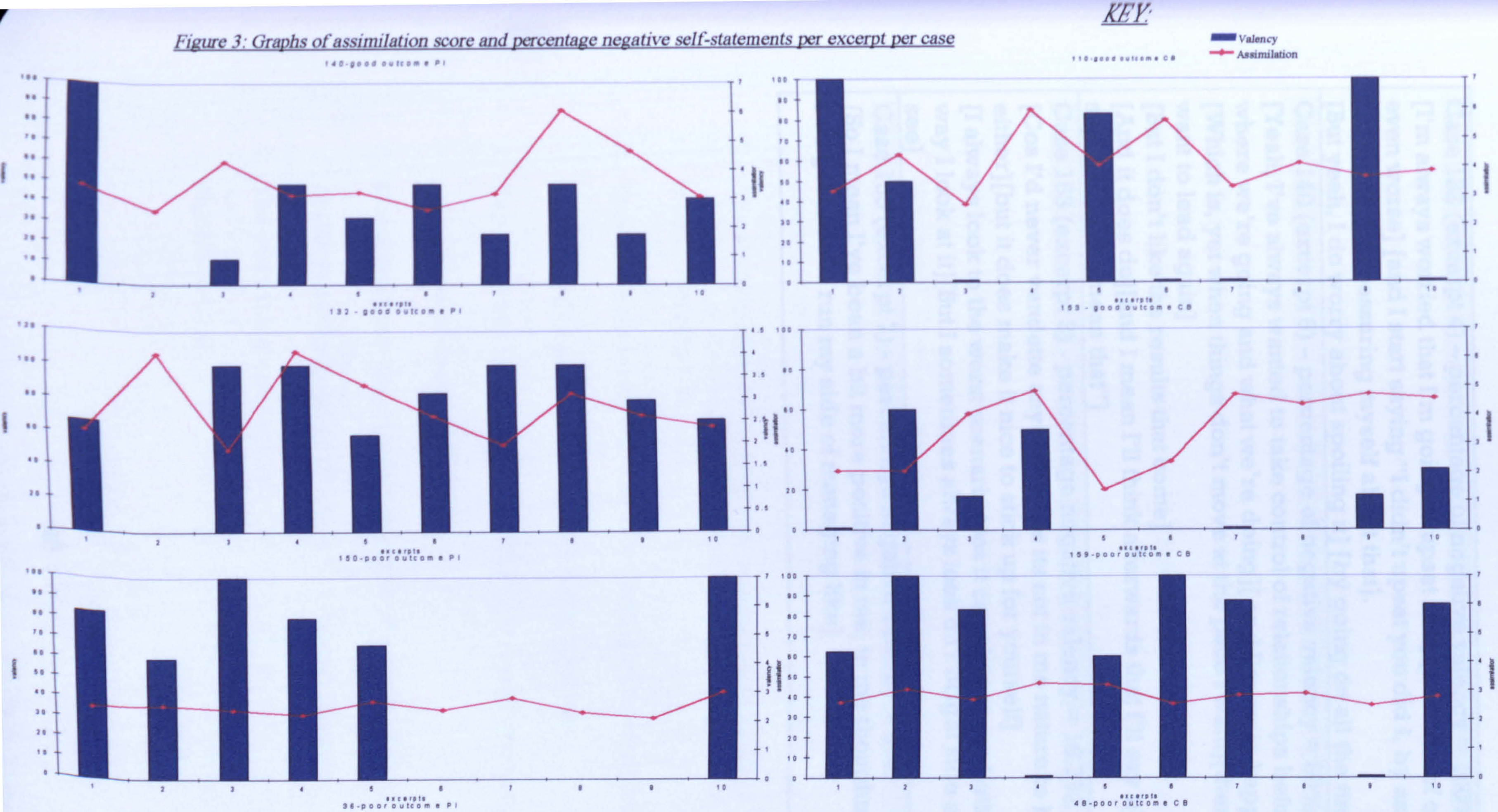


Table 10: Transcripts of client self-statements in 'sudden gains' excerpts.

Case 132 (excerpt 4) – percentage of negative valency = 100%. [I'm always worried that I'm going to upset him] [but then of course it gets even worse] [and I start saying "I didn't upset you did I, by asking you?"] [and then I'm reassuring myself about that]. [But yeah, I do worry about spoiling it] [by going on all the time].
Case 140 (excerpt 8) – percentage of negative valency = 50% [Yeah, I've always wanted to take control of relationships before][and where we're going and what we're doing][and I'm quite happy to be led] [Which is, yet when things don't move at the pace I want][then I start to want to lead again] [But I don't like the results that come] [And it does do][and I mean I'll think afterwards that I'll say it][and then I'll say "no I don't mean that"]
Case 153 (excerpt 3) - percentage negative valency = 16.7%. [Cos I'd never vendette anybody][cos its not in me nature to be nasty either][but it does make it nice to stick up for yourself] [I always look to the worst scenario 'cos it can always get better][that's the way I look at it][But I sometimes always look on't bright side as well you see]
Case 153 (excerpt 7) - percentage negative valency = 0%. [So I mean I've been a bit more positive in me, in me thoughts][and what I've got to do to run my side of managing like]

4. Discussion.

4.1 Summary of findings.

The current research applied procedures and theories of process-outcome research in an aim to develop a descriptive analysis of psychotherapy as carried out in 2+1 CBT and PI, and relate these findings to outcome. Eight cases were examined; two good outcome CB and 2 good outcome PI cases, and 2 poor outcome CB and 2 poor outcome PI cases. Both parametric and non-parametric analyses were used, depending on the properties of the data. Significant findings are summarised below.

1. PI therapists focus more on Constructing Meaning (CM) than CB therapists. Good outcome PI therapy involves higher levels of CM than poor outcome PI therapy. Good outcome CB therapy involves lower levels of CM than poor outcome CB therapy.
2. Clients receiving PI therapy had higher experiencing levels than those receiving CB.
3. Experiencing levels for clients receiving PI therapy were significantly correlated with assimilation scores.
4. Experiencing levels in good outcome PI cases were significantly correlated with excerpt order.
5. Good outcome therapy had significantly lower mean percentage of negative self-statements than poor outcome therapy.
6. The percentage of negative self-statements in CB therapy was significantly inversely correlated with assimilation scores.

These findings will be discussed in terms of process and outcome below, before discussing the methodological limitations of this study and implications of the findings.

4.2 The process of 2+1CB and PI therapy.

The following section, structured by each variable, interprets the meaning of the findings for the process of CB and PI therapy. Further on, the results in relation to the Assimilation model will be discussed, before integrating the results in the conclusions.

4.2.1 Therapist focus.

Therapist focus is one example of therapist action which has been found to be related to outcome (Castonguay & Schut, in press). Therapist focus refers to what the therapist chooses to highlight in order to re-direct the clients' attention towards therapeutically relevant phenomena, which are then explored to bring about change (Goldfried et al., 1997). Theory should play a large part in this decision making as the vast majority of psychotherapy training revolves around the use of theory based techniques in therapy (e.g. Hill, 1990).

The therapist's use of different foci in a theoretically consistent way has been previously demonstrated (Goldfried et al., 1997; Blagys & Hilsenroth, 2000) and partially confirmed in this research; PI therapists focused more than CB therapists on 'Constructing Meaning' (CM). CM is composed of

categories related to reflective discussion of past interpersonal events and inner states of mind. Subjectivity and introspection are emphasized as the therapist explores and makes interpretations (Samoilov et al., 2000). The PI therapy used in 2+1 was an integration of psychodynamic and experiential approaches, adopting an interpersonal focus in order to increase self-understanding. The CB approach used in 2+1was based on multi-modal cognitive and behavioural treatments. Problems were formulated through cycles of thoughts, feelings and behaviour, which directed the intervention towards modifying cognitions and developing self-control skills (Stiles et al., 1989). That PI therapy showed higher CM than CB therapy therefore demonstrated adherence to the models.

It was also predicted that CB therapists would focus more on 'Facilitating Action' (FA; a scale measuring expectations, behaviour and more externally based components), by adopting a model of 'doing' in the here and now, encouraging action to reinforce ideas developed within sessions and explicitly working towards goals in the future. However, CB therapists did not have significantly higher scores on the FA scale suggesting a lower than expected emphasis on external and goal-oriented foci to instigate change. There may be a number of reasons why CB therapists did not score as high as predicted on the FA scale. The 2+1 format may have provided limited opportunities to test out predictions and changes made during the session outside of the sessions as there were only two between-session periods. Aware of this, CB therapists may have focused less on setting the parameters for behavioural experiments, components of which

come under the FA scale. PI therapists on the other hand, similarly aware of time restrictions, may have demonstrated more active goal-oriented work than usual for a psychodynamic intervention, thereby bringing their FA scores closer to those of CB therapists. Indeed, PI therapists were expected to identify a focus of work within the first 20 minutes of the session (SAPU Memo 1119, 1985), suggesting that PI therapy in this format may well have been more active and specifically focused than traditional PI.

The above findings may also reflect methodological limitations however. For example, a bias may be inherent in the TFAI as a measure of the *strength* of endorsement of categories, with higher scores reflecting more frequent use of categories. If, as hypothesised, CB therapists adopt a more specific and focused approach than PI therapists, being *very* focused would not necessarily translate to a higher FA score as by definition of being focused fewer categories would be used. Also, it appears that the same FA score could be obtained if a therapist was focussing on a specific situation and asking about behaviour in that situation, and if a therapist, while exploring a client's difficulties, added in a query about current behaviour. This may be reflected in the lack of significant differences in FA scores for CB and PI therapists, respectively. A further methodological reason may be the small sample number. Larger numbers may have strengthened the trend towards higher FA score in good CB than poor CB or PI.

PI therapists had similar FA scores to CB therapists, yet significantly higher scores on the CM scale, suggesting that on the whole, PI therapists incorporated more foci during sessions. Goldfried et al. (1997) viewed similar findings that PI therapists utilised more categories within sessions than CB therapists as indicating that PI therapy was "richer" than CB therapy, an idea also proposed by Messer (1986). However, it cannot be concluded that a broader focus is necessarily a more therapeutic one as both PI and CB demonstrated equal effectiveness. Adopting a broad focus appeared to be beneficial for PI therapy while a narrower focus was beneficial for CB, and such differences are again consistent with theory. PI therapy could be regarded as requiring a 'broad' focus in order to explore the meaning of past experiences for existing relationships. CB is a problem-focused approach, aiming to bring about change in the present by developing self-management skills through discussion and experimentation. It would be hypothesised that effective operationalisation of this requires specific 'narrow' focused intervention. Therefore, moderate scores on CM and FA may illustrate CB therapists' focus on understanding the difficulties and their origins, using this information to guide the development of appropriate strategies and experiments. PI therapists' greater focus on CM may reflect exploration of the past and discussion of relationships as the main thrust of the intervention.

The interaction between therapist focus, therapy mode and therapy outcome was statistically significant. As it was not possible to carry out post-hoc tests, these results were interpreted as suggesting that good PI

had higher CM scores than good CB (which would be predicted from the above discussion), but also that good PI therapy had higher CM scores than poor PI therapy, while good CB therapy had lower CM scores than poor CB therapy. A stronger focus on CM appeared to be beneficial to PI therapy, lending some support to the hypothesis that therapist focus is related to outcome through a dose-related curve. It is suggested however that this relationship is true only when the active ingredient is theoretically consistent with the model i.e. focusing more on CM was associated with better outcome in PI therapy as the CM scale was more reflective of the PI model. Focusing more on CM appeared to be detrimental to CB therapy as the CM scale did not encompass the main aims of CB therapy. These differences are intriguing, and have a number of possible explanations. One reason may be clients' expectations of therapy. Previous research has indicated that compatibility between client expectations and therapy content may be linked to outcome (Castonguay & Schut, in press). Clients in the 2+1 project were given detailed booklets describing the therapy they would be receiving. CB therapy, termed "prescriptive" therapy was described as focusing on two areas "first, things you do, and second, the way you think about things", and was "problem focused and practical", where the therapist would set up experiments and challenge thoughts (SAPU Memo 1118, 1985). PI, on the other hand, was described as focusing on "your feelings....and how you feel about yourself and other people", highlighting the exploration of the interpersonal nature of the difficulties through the therapeutic relationship, encouraging "staying with" feelings rather than "bottling up" (SAPU Memo 1119, 1985). It would be predicted

that clients attending CB therapy arrived expecting an action oriented therapy. When the therapist focused more on CM, the expectations of the clients were not met, potentially leading to a poorer outcome. Similarly, those attending PI therapy were expecting a more exploratory experience. When these expectations were met by the therapist through the higher use of CM, a better outcome was achieved.

It was suggested above that a 'broad' or 'narrow' therapist focus was beneficial for PI and CB therapy, respectively. This may be supported by the finding that good outcome PI therapy involved higher scores on the CM scale, while good outcome CB involves lower CM scores. It is possible that the power of good outcome therapy lies in the ability of the therapist to be appropriately targeted. Previous research has demonstrated that one aspect of therapist competence most contributing to good outcome in CB therapy is the skill of the therapist in structuring treatment (Llewelyn & Hardy, 2001). In structuring the treatment it would be hypothesised that the therapist targets theoretically relevant factors. It is suggested that, for PI therapists, the target is a broad one as measured by the CM scale, with greater emphasis on this scale associated with better outcome. CB therapists on the other hand would be aiming to have a specific and focused target. Lower CM scores in good outcome CB therapy may reflect successful focusing away from broader material (as measured by the CM scale) in order to achieve targeted behavioural change.

Therapist focus was not found to differ over the course of therapy. Previous research had not suggested a specific pattern of therapist focus. The lack of statistically significant differences meant that it was not possible to suggest any patterns. This lack may have been due to the short duration of the treatment. A longer period of therapy may have provided a more consistent picture.

4.2.2 Experiencing (EXP).

The experiencing scale measures how involved the client is in therapy through the way they talk about their difficulties. Low levels of experiencing are indicated by impersonal and superficial discussion, while higher experiencing levels are reflected through exploration of feelings and developing a greater understanding of the self.

It was expected that as PI focuses more on the exploration and discussion of feelings and their significance, higher levels of experiencing would be shown by clients. Results from the current research confirmed that clients receiving PI therapy had significantly higher experiencing scores than those receiving CB. That clients receiving CB therapy showed moderate levels of experiencing confirms Castonguay et al.'s (1996) findings, suggesting that experiencing may indeed be a necessary although not sufficient element for change in CB therapy. One reason why experiencing is higher in PI than CB therapy may be related to previous research showing that the use of interpretations by the therapist increases experiencing and insight (Hill, 1990). It would be predicted that PI therapy

involved a greater use of interpretations. Higher experiencing scores in PI therapy may therefore be a direct result of a higher use of interpretations compared to CB therapy. CB therapists may have "dissipated" experiencing (Wiser & Goldfried, 1993) by focusing more on rationality and self-management. Research on the client's perception of therapy supports such suggestions. Hardy et al. (1998) found that clients rated CB as more problem-focused and encouraging behavioral change compared to PI therapy which was rated as more focused on emotion. Clients went on to rate CB therapy as "smoother" (more comfortable and less distressing) than PI therapy, which appeared to be more of an emotional 'roller-coaster'. The current findings that PI therapy involves higher experiencing levels than CB therapy are therefore consistent with both theoretical models and client perceptions.

These results, however do not necessarily mean that emotional experiencing is not a component of CB therapy. It appeared that PI therapy, through its search for meaning in the therapeutic relationship in sessions, encouraged emotional experiencing *within sessions*. CB on the other hand involved lower levels of experiencing during sessions in which cognitive and behavioural tests were set up, but may have higher levels of experiencing *outside* the session during the implementation of behavioural experiments. Therefore, it may be that experiencing is also associated with change in CB therapy, but due to therapeutic events occurring outside the sessions. PI could be regarded as a large behavioural experiment, providing a situation within the session in which an individual can explore

and work through their own thoughts and assumptions about relationships in order to bring about change (Shapiro & Firth, 1985), while CB attempts this primarily outside the session.

Experiencing levels did not show a statistically significant interaction with therapy mode and outcome. Trends in the data may suggest that while good PI had higher experiencing scores than poor PI, good CB had lower experiencing scores than poor CB. In the previous discussion about therapist focus it was suggested that high CM scores in CB therapy detracted from its problem-solving target which was associated with poor outcome. Similarly, it may be that higher experiencing levels in poor outcome CB (possible as a result of the higher focus on CM) hindered achieving the therapeutic goals. That is, the problem-solving approach of CB required a focus on action and planning behavioural experiments to test out cognitive change made during the session, and high levels of experiencing might detract from this. Drawing from the coping with illness research (Steptoe & Wardle, 1994), it could be said that CB therapy depends on a problem-focused coping style in which efforts are directed towards working a way around the source of difficulty, as opposed to emotion-focused coping which aims to modify the emotional response to the difficulties. The content of CB may require a stepping away from emotion in order to discuss action. Therefore, poor CB showing, non-significantly, higher experiencing scores than good CB may reflect a tendency towards a less focused intervention where the parameters in which to discuss cognitive and behavioural change were not sufficiently

structured and containing to prevent movement into emotion-focused talk. Nevertheless, it must be remembered that the interaction between therapy and outcome was not statistically significant, so these suggestions are speculative only.

An analysis was carried out to explore whether experiencing levels changed over the course of therapy. As previous research had shown inconsistent results (Klein et al., 1986), it was unclear what the profile of experiencing would be in very brief therapy. Analyses indicated that experiencing levels in good outcome PI therapy were significantly correlated with excerpt order. This supports the hypothesis that experiencing is the active ingredient for change in PI therapy, suggesting that this process increases over the course of successful therapy as the client is facilitated in developing their narrative. It was inferred that this did not occur in poor outcome PI therapy. If the outcome of CB therapy is less dependent on experiencing we would expect little change in experiencing over time for either good or poor outcome CB. This was supported by the lack of significant correlations with excerpt order for CB therapy, although it was interesting to note the suggestion of a pattern that experiencing actually decreased over the course of therapy. It may be that having explored the difficulties initially, CB therapy then focused on action, which as discussed above may preclude against high experiencing. The mixed picture of patterns of experiencing over time supports conclusions from previous research that the pattern of experiencing over time need further clarification.

4.2.3 Cognitive change.

Measuring cognitive change is a complex process, and measures are only now evolving which can detect cognitive change over the course of therapy. However, no adequate assessment of cognitive change was available which would be appropriate for use with excerpts from two therapy sessions. The Patient Cognitive Change Scale (PCCS: Tang & DeRubeis, 1999) was piloted on the current 2+1data, but after contact with the authors of the scale it became apparent that the scale was being developed, and was designed for use with a higher number of sessions which produced cognitive change in thoughts and beliefs. Instead therefore a 'proxy' measure of cognitive change was adopted for this study based on previous work by Cooper (1990) and Barton (1999). Clearly, the validity and reliability of such a system was not known, but the inter-rater reliability values obtained suggested sufficient reliability for the current study.

It was predicted that as CB therapy's main focus is on cognitive change through the modification of behaviour, clients receiving CB therapy would be more likely to show a reduction in negative self-statements over time compared to clients receiving PI therapy, which as described above, focused more on emotion. However, no statistically significant correlations were found between excerpt order and percentage of negative self-statements for either CB or PI therapy. Values for all clients though were negative suggesting that as time went on, negative self-statements

decreased though not to a significant degree. This provides tentative, though not statistically significant, support for Person and Miranda's (1995) proposal that most therapies show an element of cognitive change. The trend may not have approached statistical significance because of methodological limitations such as the small number of data points (a number of excerpts were found to contain no self-statements as defined), the use of an insufficiently sensitive measure or the possibility that the aggregation of data into percentages obscured differences. On the other hand, the 2+1 format may have been too short a time period in which to achieve significant cognitive change. It has been suggested that cognitions are only available for change once they have been activated, termed the 'activation hypothesis' (Persons and Miranda, 1995). Activation is proposed to occur through life events or negative mood. It is possible that the lack of statistically significant differences between CB and PI therapy are related to the 2+1 format being too short a duration of treatment to achieve full activation of underlying cognitive structures. There was limited opportunity for life events during the course of the two sessions, and the mood of the clients may not have been sufficiently negative (given that clients scored within the mild-moderate depression range at screening) to activate the underlying structure within two sessions. The finding that CB therapy did not show statistically stronger relationship between negative self-statements and time leaves it unclear as to what factors lead to change in CB therapy. As noted above, the CB applied in the 2+1 format was more behavioural in nature than usual. It may be that, for this study, a measure of

behavioural change would have detected more differences between CB and PI therapy.

The difference in negative self-statements overall in CB and PI therapy was statistically non-significant, possible due to the similarity in values in poor outcome CB and PI therapy. Patterns in the data however suggest that there is a trend towards higher percentages of negative self-statements in PI compared to CB, providing tentative confirmation of previous findings such as Teasdale & Fennell (1982). Statistically significant differences were however found between good and poor outcome therapy. Although it was not clear where this significant difference lay, it would be expected that it was in the difference between good and poor outcome in CB therapy. Good outcome CB therapy contained half the percentage of negative self-statements as poor outcome CB therapy. It is possible that the clients in good CB therapy were less negative about themselves from the start. However, the pattern of BDI scores for all clients did not indicate that there were any difference between groups on initial presentation. Alternatively, it may be that good and poor outcome CB and PI therapy did indeed involve different processes. For example, in discussing clients' difficulties. it may be that PI therapists encouraged submergence in emotive issues in order to bring about change (thus the higher levels of experiencing), which may lead to higher frequencies of negative self-statements. CB therapists on the other hand have a protocol by which to intercept cycles of negative thinking by explicitly challenging negative depressogenic cognitions such as all-or-nothing statements ("it's all awful") or negative

attributions, thus preventing clients from ruminating on negative cycles. Possibly therefore, successful CB therapists were more able to move their clients away from cycles of negative self-statements through an active process of refocusing and structuring, leading to fewer negative self-statements. Whether due to client or therapist variables this was not achieved in poor outcome CB where the frequency of negative self-statements remained high. The difference between good and poor outcome PI therapy was very small. As suggested above, PI therapy may depend on experiencing for change, so it would be expected that there would be less of a difference in negative self-statements in good and poor outcome PI therapy.

4.3 Summary of preceding section.

PI therapists focused more than CB therapists on the CM scale. This implied that PI therapists gave greater emphasis to past events, relating these to clients' difficulties in relationships with people and disharmony within the client themselves. PI therapy was also associated with higher levels of experiencing. It was suggested that, by adopting an exploratory approach to the difficulties, therapists encouraged higher experiencing in the clients, and these higher levels of experiencing were required for good outcome. On the other hand, it was inferred that CB therapy benefited more from a specifically targeted therapist focus which concentrated on cognitive change to improve symptoms. Clients in CB therapy appeared to benefit from lower levels of experiencing within sessions, possibly as this left more room for discussion of behavioural

experiments and cognitive challenging. It was found that good outcome CB therapy was associated with fewer negative self-statements, supporting the hypothesis that CB therapy exerts its benefits via cognitive change, rather than experiencing. Both CB and PI therapy therefore appeared to benefit from therapist focus and client changes consistent with the underlying theoretical models. Additional factors such as consistency between client expectations and the content of therapy were also hypothesised to contribute to good outcome.

What is emerging is that CB and PI therapy, even of this very brief nature, differ in content and appear to tread different paths towards equal effectiveness.

4.4 The relationship between the process of CB and PI therapy and immediate outcome as measured by the Assimilation model.

4.4.1 Therapist focus.

In an aim to relate therapist focus to immediate outcome, the CM and FA scales were correlated with assimilation levels. No significant correlation was found between the two data sets, suggesting that what the therapist focuses on had no significant immediate impact on the assimilation progress of the client. Apart from Stiles, Shapiro, Harper & Morrison's (1995) study of therapist contribution to a single clients' assimilation progress, there has been relatively little research to date relating assimilation to therapist variables, and therefore little theoretical

development in this area by which to discuss these results. There may be a number of methodological reasons for this finding. For example, the Assimilation model was developed very much as a client-based model, therefore it may detect therapist actions only weakly, or only after a time lag which was not detected in the correlation analysis. Alternatively, it is expected that immediate outcome as measured by the Assimilation model would be more vulnerable than more meta-level outcome to moment-by-moment changes. Although therapist focus appeared to be related to overall outcome (as discussed above), it is possible that the profile of CM and FA scores within-session was not consistent enough to show a significant association with assimilation.

4.4.2 Experiencing.

Immediate outcome as measured by the Assimilation scale was significantly associated with higher experiencing levels in PI therapy, confirming the conclusions of previous research (Klein et al., 1986). Experiencing scores in CB therapy were not significantly correlated with assimilation, but it was interesting to note that the values were negative, suggesting an inverse non-significant relationship. Taking the assimilation model as a measure of immediate outcome, these findings support the hypothesis that PI is dependent on experiencing to achieve its aims, while low experiencing levels are associated with good outcome in CB, although this latter suggestion is inferred rather than being statistically significant. This suggests that in PI therapy, discussion characterised by deeper

exploration of emotional experiencing, is associated with progression on the Assimilation scale. However, CB appears to have a different active ingredient which assists or is a consequence of assimilation. This supports previous research findings of better predictive validity for experiencing in client-centered therapies, if we assumed that PI therapy was more based on client-centered theory than CB therapy. These findings however may be an artefact of the experiencing scale having developed from client-centered therapy, and therefore measuring the type of emotional processing seen in a therapeutic framework such as PI rather than CB therapy. CB therapy could conceivably involve as great a degree of 'experiencing', but of a type which is not detected by the experiencing coding scheme.

Wiser & Goldfried (1993) found that PI therapists rated sessions with higher experiencing levels as important whereas CB therapists rated sessions with lower experiencing levels as more important, thus confirming that PI therapy depends on high experiencing for good outcome. In an aim to relate this phenomena to 2+1 therapy, 'significant' excerpts of sessions were selected. These were defined as movement up one or more levels on the assimilation scale. Although somewhat arbitrary, this definition did comply with the view that movement on the assimilation scale is a significant event and one which implies some qualitative difference with portions in which no movement on the assimilation scale was made. It is notable that the majority of 'significant' excerpts as defined in this way occurred in good outcome therapy.

No significant differences were found in experiencing scores in 'significant' as opposed to 'non-significant' portions of sessions, either by therapy or outcome group. There was a trend for experiencing scores to be higher in PI therapy, but this may be an artefact of the overall higher levels of experiencing in this therapy mode. As noted in the discussion on therapist focus and assimilation, there may be a time lag between experiencing scores and 'significant' movement on the assimilation scale, so that measuring experiencing scores just at the point where the assimilation movement has been achieved is simplistic. Measuring experiencing scores in the excerpts contiguous with the significant portions would have been helpful, but would have required sequential analyses, beyond the scope of this dissertation. Clearly however these results may also be due to the small number of data points in the 'significant' portion group and the narrow definition of significance used. If the definition of significance had involved movement up a greater number of assimilation levels, clearer associations may have been found.

4.4.3 Cognitive change.

A correlational analysis of the percentage of negative self-statements with assimilation scores revealed that these two factors were significantly inversely correlated in CB therapy. This indicated that in CB therapy, an increase in assimilation level was associated with a decrease in the percentage of negative self-statements. It was proposed above that CB

therapy depends on changes in factors other than experiencing to achieve a good outcome. These findings suggest that change in the percentage of negative self-statements is related to immediate good outcome in CB therapy as measured by the Assimilation scale. From the lack of significant correlation between negative self-statements and assimilation in PI therapy, it could be reiterated that PI therapy appears to derive good outcome from the emotional focus of the therapist and the emotional experiencing of the client, rather than cognitive change.

As part of the growing body of literature on 'sudden gains' Tang, Luborsky & Andrusyna (2002) reported that sudden gains in "supportive-expressive" therapy, a dynamic psychotherapy, were similar in frequency and timing in sessions to those seen in CB therapy. Their impact and relation to long term outcome however was not as significant in "supportive-expressive" therapy as in CT. The current research found equal numbers of 'sudden gains' (defined as movement up two or more levels on the assimilation scale) in both CB and PI therapy, occurring at similar times according to excerpts, indicating that 'sudden gains' are indeed a phenomenon seen over different therapy types. All but one of these 'sudden gains' occurred in good outcome therapy, supporting Tang et al.'s (2002) proposal that 'sudden gains' could be regarded as the first step in an "upward spiral" of significant improvement in symptoms, as shown by the BDI scores in the good outcome group clients. There was however a very small number of such 'sudden gains' in the current study, and only four of these also had data on the valency of self-statements. Furthermore, the 'sudden gains' in

CB therapy with this additional data on self-statements came from one individual only, and therefore must be treated with caution.

No significant difference was found in the percentage of negative self-statements in 'sudden gain' as opposed to 'non-sudden gain' portions of CB or PI therapy, possibly due to the very small amount of data. Interestingly however, PI therapy showed a slightly higher percentage of negative self-statements in the sudden gain portions compared to non-sudden gain portions, although this was not a significant effect. This is the converse of the pattern in CB, hinting that sudden gains on the assimilation model may not be related to cognitive change in PI therapy in the direction seen in CB. For 'sudden gains' in PI therapy, a higher frequency of negative self-statements may indeed be required if we view them as indicators of deep exploration of difficulties (which is suggested by the association between experiencing and assimilation discussed in the previous section) . Whereas, CB therapy's focus on cognitive challenging is hypothesised to lead to 'sudden gains' associated with fewer negative self-statements. Study of the transcripts indicated that during 'sudden gains', clients receiving PI therapy described interpersonal conflicts and an awareness of where the difficulties lay but with comparatively little indication of positive views for the future or hope of change through self-management. On the other hand, the transcript for the CB client had a tone of self-management and optimism, providing potential qualitative support for the hypothesis that 'sudden gains' in assimilation are associated with less negative self-statements in CB therapy.

Further exploration of 'sudden gains' with the therapist focus and experiencing variables may have been informative in clarifying whether specific factors are indeed the main contributors to 'sudden gains' in very brief therapy (Tang et al., 2002). It would also have been interesting to explore negative self-statements in the excerpts preceding and following assimilation change, rather than just in the excerpt where the movement was achieved. However, this would have required more sophisticated sequential analyses which would have been difficult given the very small number of data points.

4.5 Summary of preceding section.

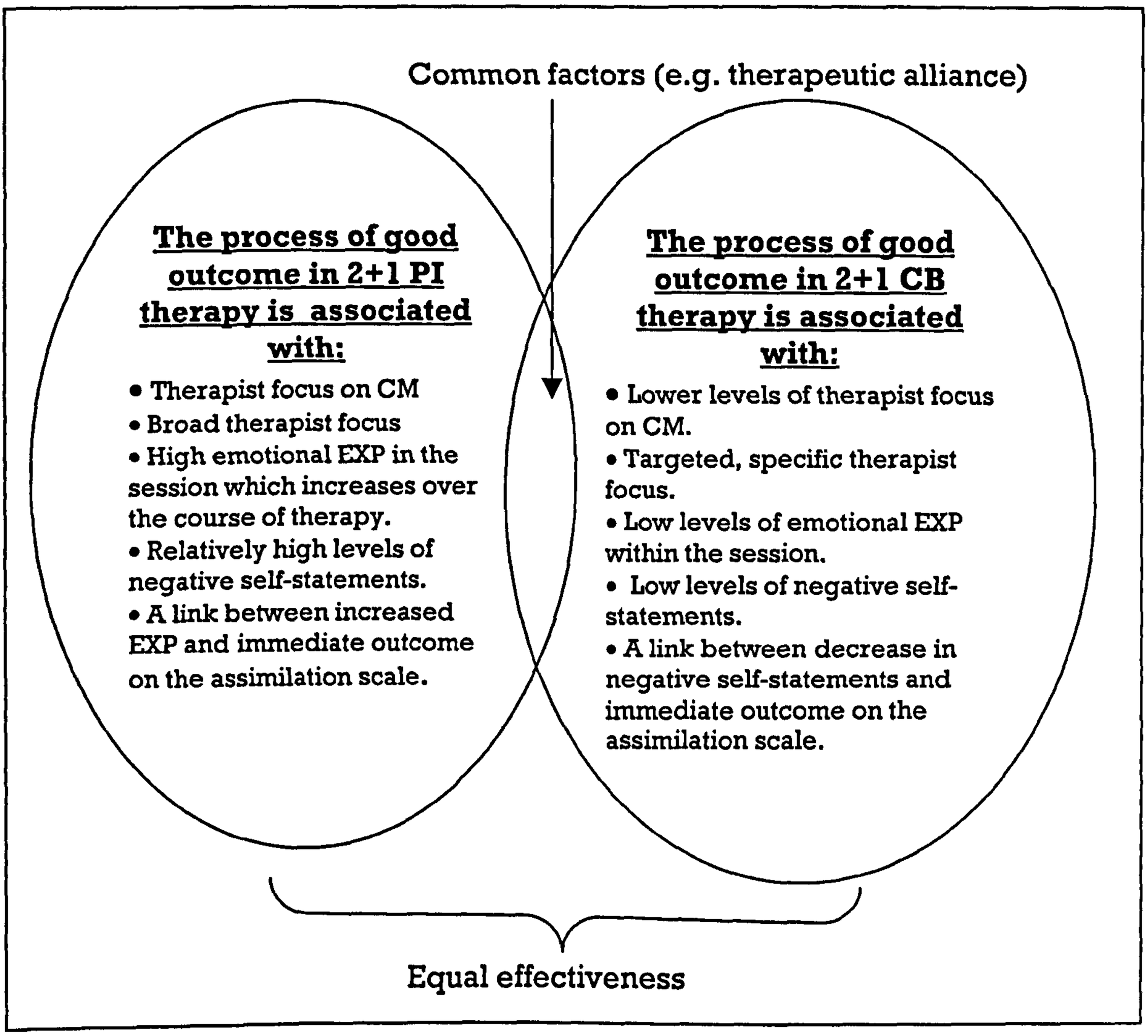
Overall, changes in assimilation appear to be related to experiencing in PI therapy and cognitive change in CB therapy. These findings support proposals above of the mechanisms of action in very brief therapy, that PI therapy requires experiencing as an active ingredient while CB therapy requires cognitive change. These change processes appear to apply to both immediate outcome (assimilation) and overall outcome. Use of correlational analyses meant that it was difficult to conclude causation i.e. in PI therapy whether discussion of problematic experiences led to high experiencing levels which led to the assimilation of problematic experiences, or whether experiencing was a product of assimilation, or was due to a separate third factor. Similarly, in CB therapy whether discussion of problematic experiences led to fewer negatives self-statements which led to assimilation movement, or whether a decrease in

negative self-statements was a product of assimilation movement. There was too little assimilation data to provide any significant differences in CB and PI therapy for phenomena such as 'significant' gains and 'sudden' gains. Nevertheless, the Assimilation scale is potentially a valuable source of data on within-session change for brief and longer term therapies.

4.6 Summary of findings on the process and outcome of CB and PI 2+1 therapy.

The findings reported here suggest that although 2+1 CB and PI therapy have been shown to be equally effective, the routes to change do appear to be partially different. The preceding discussion is summarised in Figure 4. A clearer picture emerged of PI rather than CB, possibly due to potential biases inherent in the coding schemes. Consequently, the summary below incorporates statistically significant findings and inferences drawn from them and is speculative only. The current research did not study the contribution of common factors such as the therapeutic alliance, therapist empathy etc. to outcome. A large body of literature has however demonstrated the significant impact of such common factors on outcome, at least in longer term therapy (Llewelyn & Hardy, 2001). Therefore, a section for common factors has been inserted in to the diagram in acknowledgement of this.

Figure 4: Diagrammatic summary of interpretations of findings on process and outcome of CB and PI 2+1 therapy.



4.7 Methodological critique.

4.7.1 The 2+1 data.

Data for the current research was taken from the 2+1 research project (Barkham et al., 1999). While this research has demonstrated a range of interesting findings, it is worth acknowledging the limitations of the data. For example, it is questionable whether CB and PI can be adequately administered in just two therapy sessions. In particular, the theoretical

basis of PI therapy requires a number of sessions within which to explore the therapist-client relationship and the emergence of anxieties and defences. In terms of CB therapy, the model used in 2+1 was more behavioural in nature than usual CBT (Hardy et al., 1998), but was limited in having only two between-session periods in which to carry out behavioural experiments.

The generalisability of the findings are hindered by the format of 2+1.While providing an opportunity to study a whole course of therapy, 2+1 is highly unique in its structure and it is unclear how much of the results is a product of this unique format rather than differences in the process of CB and PI therapy per se. Secondly, as with the majority of comparative studies, the therapy used was manualised and rigidly controlled. It is therefore unclear how generalisable these results are to the everyday clinician who will not be following such strict therapeutic models.

4.7.2 Design.

The use of only eight cases in the current study limits the statistical power and the generalisability of the findings, although they were selected quasi-randomly from a pool of appropriate cases (i.e. fulfilling the criteria for good and poor outcome cases). However, these eight cases represented the maximum amount of data for intensive analyses by the raters, who were providing their time voluntarily. The eight cases were seen to be

representative of the research group as a whole. However, it is worth noting that there were fewer men represented in this sample of eight than in the sample as a whole (25% males in this sample compared to 58% men in the research group as a whole, Barkham et al., 1999). The two men in the current sample received CB therapy. It was not the aim of this research to explore the influence of gender on therapy process and outcome. However, the potential for different responses of males and females to highly focused therapy packages cannot be ignored as a potential confounding factors in the results.

Although occasionally inter-rater reliabilities were low, these low values tended to be for single raters only. Statistical advice recommended that the mean of raters be used as the most informative of values as it provided an estimated mean for all raters (Watson, personal communication 2002). These values tend to be more robust and were considered adequate for the analyses used. The raters available for this research had a range of psychological experience, from assistant psychologists to third year trainees. It is possible that the differing degrees of psychological knowledge and experience was a confounding variable for the rating procedure, leading to different readings of the transcripts across and within coding schemes. It has been stated with regard to the experiencing scale, for example, that clinical 'naivety' is preferable as the rater is more likely to be free from bias about client type, therapy mode and research aims (Klein et al., 1986). Although rater experience is acknowledged as an additional un-controlled variable in the research, time and financial

constraints meant that it was not possible to recruit raters with similar experiences for each coding scheme.

In order to carry out a focused piece of research, three variables only were studied. This inevitably meant that many other variables were ignored such as the interpersonal style of the client, the therapists' skill and the quality of the therapeutic relationship, all of which have been found to influence outcome (Castonguay & Schut, in press). Discussion of the factors which were studied therefore must be placed within the context of the many other variables which were also exerting their influence on the process and outcome of therapy. In addition, these three factors were coded through different sized discursive units, from idea units to whole excerpts. Although all measures were aggregated up to the level of excerpts (unfortunately with the risk of interesting data being lost in this process), it is possible that this initial lack of standardization may make drawing conclusions across factors difficult as it would not be a comparison of 'like with like'.

The experiencing scale is a well established scale, with high validity and reliability demonstrated in a number of studies (Klein et al., 1986). The TFAI however has only recently been developed and requires further study to both establish its psychometric properties and its use as a pan-theoretical measure, in light of possible biases (such as a bias towards diversity and richness of therapist focus) discussed above. Nevertheless, the TFAI was an appropriate and accessible measure in terms of time and

labour required. The measure of cognitive change was limited in that only self-statements were coded for valency, and the rater training manual was developed for use specifically in this study. However, the manual was based on previous studies of cognitive change, and appeared to provide a sufficiently reliable scheme for the current study, according to inter-rater reliability values.

Using a quantitative methodology for analysis of the sessions provided an opportunity to define in quantifiable terms the processes occurring during therapy. However, adopting these strategies precluded studying the richness of a developing narrative over the session. Process research as employed in this study is an investigation of the words used. Translating these into numbers, using intensive quantitative analysis, provided a method by which to study differences in terms of statistical power, but risked ignoring the richness and subtleties of verbal communication. Criticism of some process-outcome research, and the current research, which adopted a quantitative methodology are the inadequacy of statistical methods used in capturing the complexity of the change process, and the upholding of the notion that 'more is better' i.e. that the more the active ingredient is present the better the outcome will be (Llewelyn & Hardy, 2001). As a consequence, the context and timing of events are ignored and correlations become problematic in assuming that the frequency of occurrence equals its importance. The comparative and correlation data used in this study provided descriptive results only and cannot indicate causality or interaction (Stiles, 1988). However, the type of statistical

analyses needed to capture the fine-grained interactions within the therapeutic process, such as task analysis or sequential analysis, are highly complex and beyond the constraints of the current research.

4.8 Clinical Implications.

The current emphasis on clinical governance and evidence based practice has provided clinical psychologists with a framework within which to make clinical decisions and provide effective treatments. Recent publications such as government guidelines (DoH; 2001) have made recommendations for therapy choice based on outcome studies. As discussed above, the available research suggests an overall equality of outcome for different types of psychotherapy. However, neither CB nor PI are100% effective. The current research project aimed to identify the processes of two very different theoretical and clinical models and how these related to outcome in an attempt to explore how to maximise the effectiveness of the two. The models of change in CB and PI therapy were distinct, relying on different factors to achieve their therapeutic aim. While supporting the Dodo-bird verdict in that effectiveness of CB and PI was equal, the findings suggest that in very brief therapy at least, specific factors significantly differentiate CB and PI therapy.

It has been shown that PI and CB, as provided by experienced therapists following manual based treatment, show differences in content, although they had similar outcome. Findings from research such as this current project into 'pure' models do not however translate easily to therapists, the

majority of whom describe themselves as "eclectic" rather than adhering to any single form of therapy (Kopta et al., 1999). While deconstructing studies have tried to identify individual effective components of therapy, it is unclear whether these effective components are being used in eclectic therapy or how they perform within the context of eclectic therapy.

Although Goldfried et al. (1997) highlighted the need for studies of effectiveness of "integrated" therapy, it is expected that each therapist's combination of individual components making up their form of "integrated" therapy is different, thereby making generalisable conclusions from such studies difficult. As the current results indicate that theoretically consistent interventions are effective, it could be suggested that theoretically 'pure' interventions should actually be endorsed to a greater degree in clinical practice. Findings suggest that at least for short-term interventions, therapists should perhaps adopt a targeted, focused approach based on specific theory and techniques in order to provide effective therapy.

Clinical psychologists are currently working within an NHS which is driving for brief therapy. The above findings suggest that very brief therapy can be effective. Good outcome brief therapy appears to be associated with therapist focus on theoretically relevant components, leading to clients experiencing feelings and cognitions which are consistent with the theoretical model. It is suggested therefore that brief therapy would benefit from adherence to manualised treatments, relying on specific techniques in addition to common factors to increase outcome.

What is less clear is whether such high adherence to a model is as beneficial in longer-term therapy, which may require a greater degree of therapist responsiveness and ability to change foci according to the client's needs. It is possible therefore that short term and longer term therapy rely on different factors for good outcome, as suggested by Barkham et al. *(1999). Awareness of this may influence the planning and provision of* psychotherapy by therapists working in different clinical setting and with different clients who require either shorter or longer term therapy.

4.9 Future research.

Despites its burgeoning literature, process research has so far identified few processes which reliably relate to outcome (Llewelyn & Hardy, 2001). In the current research, although some interesting pointers have emerged, inevitably more questions than answers have been raised.

Therapist focus, experiencing and negative self-statements are all components of larger concepts and therefore reduce the likelihood of capturing the true complexity of the therapeutic process. So, for example, the disadvantage of breaking therapist action into measurable components such as therapist focus is that information on the quality, content and function of therapist utterances are ignored (Goldfried et al., 1997). Similarly, experiencing is only one component of the emotional experiences of the client, just as negative self-statements are one element of cognitive change. All coding schemes measured the frequency of an occurrence, which, it has been argued is not a sufficient picture of therapy,

as function of a factor may differ even if frequency doesn't (Llewelyn & Hardy, 2001). Further research has the difficult task of developing more comprehensive coding schemes which capture more of the complexity of the process while continuing to be practicable in process research.

Client variables have been less commonly studied than therapist variables in process research, maintaining "the therapist as the hero of the therapeutic encounter" (Maione & Chenail, 1999). The current findings suggest that client factors, such as experiencing and cognitive change, are potentially illuminating variables in linking process to outcome. Further research is needed to clarify these links and to explore to what degree client factors are related to the therapists' action and how much are determined by the pre-existing style of the client. Calls have been made previously for more complex analyses of the dyadic interaction of therapy through both qualitative and quantitative methods. None of the factors studied occur within a vacuum, and the 'procedural dance' of therapy is missed by looking at either therapist or client factors. It was hoped that this limitation would be met to some degree by looking at both therapist and client factors in the present study. Although this was done, it provided little clue as to the actual interaction between therapist and client. Therefore, sequential analyses of therapist and client action would provide a clearer picture of how the individual components interact within the therapeutic relationship. Furthermore, exploration of the interactions between the three variables studied here would be interesting, such as the relationship between cognitive change and experiencing.

In the search for active ingredients of therapeutic change, the focus of process research to date has been on negative symptom improvement as measured by such tools as the BDI. The BDI however has been found to be potentially more of a measure of what CB does, rather than being truly pan-theoretical (Hardy et al., 1998). Negative symptom change is only one component of therapeutic progress (Reid, 2001) which could also be hypothesised as including acceptance of symptoms or increase in positive affect or cognitions . The latter would be particularly interesting given Barton & Morley's (1999) finding that positive thinking was more present in depressed people than expected from the traditional model that depressed thinking equals negative thinking. Other markers of outcome could be clinically significant change on process measures such as the experiencing scale or scales of cognitive change. Research adopting different measures of outcome may reveal many other different interesting process-outcome links. Further research using therapy factors as outcome measures may also provide a valuable fusion of process and outcome research in order to provide a broader perspective on therapeutic change. These methodological changes need to be accompanied by more sophisticated theoretical models of change.

The issue of studying pure forms of therapy while the majority of therapists describe themselves as 'eclectic' has been discussed. In 1986, Messer described the sacrifices and gains of integrating CB and psychoanalytical approaches. Sixteen years on, the same issue is still being debated while

research has not moved on to explore in any depth the effectiveness of integration and eclecticism (Goldfried et al., 1997). A strong message from process research has been that much closer links are needed between what is actually being done in everyday clinical practice and research practices, potentially through the crossover of therapists into research and vice-versa. Further studies of the relationship between therapist and client actions and outcome in naturalistic clinical settings would provide a clearer picture of how the factors studied here present in 'everyday' therapy.

4.10 Conclusions.

The current research aimed to explore whether the factors of therapist focus, experiencing and cognitive change operated in mode-specific ways in CB and PI therapy. While focusing on these three specific factors, it is important to acknowledge the role of common factors such as the therapeutic alliance on outcome which remained unexplored in the current research. Some interesting findings were obtained, suggesting that indeed, very brief CB and PI therapy tread partially different pathways towards equal effectiveness. Good outcome PI appeared to involve a broad therapist focus on emotions and constructing meaning, and high levels of emotional participation and exploration by the clients as measured by levels of experiencing. Good outcome CB therapy, on the other hand, appeared to involve a more specific therapist focus, targeting behavioural change and challenging negative self-statements to bring about symptomatic improvement in clients. Although clients in CB therapy showed a degree of emotional experiencing, high levels appeared to

detract from the specific focus of CB, associated with poorer outcome. These differences appeared to influence immediate outcome as measured by the Assimilation scale as well as overall outcome. Although providing an interesting snapshot of the process of CB and PI therapy, these findings did not explore the interactions between the different variables and outcome. Further research is required which uses more complex statistical procedures and/or intensive qualitative analyses to explore how therapist, client and other factors influence the process and outcome of therapy. One clinical implication of these findings is that strict adherence to the theoretical framework of a therapeutic approach appears to be beneficial in very brief therapy at least. Does this imply that, rather than adopting an integrative therapeutic stance based on personal style and orientation, therapists should become competent in a theoretical model and adhere to it closely in order to provide the most effective treatments? Such questions need to be addressed in research involving both clinicians and researchers, in naturalistic settings. In conclusion therefore, these findings indicated that equal effectiveness is not equated with equality in the content of therapy, suggesting a picture of the process of CB and PI therapy which, although not conclusive in itself, may contribute to the clarification of the complex nature of change in psychotherapy and what is meant by therapeutic change.

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6. Appendices.

1. Summary of Assimilation scale
2. Assimilation ratings
3. Summary of Therapist Focus on Action & Insight scale
4. Summary of Experiencing scale
5. Summary of valency categories
6. Letter of ethical approval
7. Worked example of obtaining CM and FA percentage totals
8. Transcripts of excerpts with higher CM and FA scores
9. Transcripts of excerpts with highest mode and peak experiencing scores.
10. Transcripts of self-statements with range of percentage of negative self-statements.

Appendix 1: Summary of Assimilation scale (Stiles et al. 1991)

Level	Name	Description
0	Warded off	Content is unformed; client is unaware of problem. An experience is considered as warded off is there is evidence of actively avoiding emotionally disturbing topics. Affect may be minimal, reflecting successful avoidance, or diffuse and negative.
1	Unwanted thoughts	Content reflects emergence of thoughts associated with discomfort. Client prefers not to think about the experience; topics are raised by therapist or external circumstances. Affect involve negative feelings – anxiety, fear, anger, sadness. However, the feelings are unfocused, and their connection with the content may be unclear
2	Vague awareness	Client acknowledges the existence of a problematic experience, and describes uncomfortable associated thoughts, but cannot formulate the problem clearly. Affect includes acute, intense psychological pain or panic clearly associated with the problematic thoughts and experiences.
3	Problem statement/clarification	Content includes a clear statement of a problem-something that could be or is being worked on. Affect is negative but manageable, not panicky.
4	Understanding/Insight	The problematic experience is placed into a schema, formulated, understood, with clear connective links. Affect may be mixed, with some unpleasant recognitions, but with curiosity or even pleasant surprise of the "aha" sort.
5	Application/working through	The understanding is used to work on a problem; there is reference to specific problem-solving efforts, though without complete success. Client may describe considering alternative or systematically selecting courses of action. Affective tone is positive, businesslike, optimistic.
6	Problem solution	Client achieves a successful solution for a specific problem. Affect is positive, satisfied, proud of accomplishment.
7	Mastery	Client successfully uses solutions in new situation; this generalizing is largely automatic not salient. Affect is positive when the topic is raised, but otherwise neutral.

Appendix 2: Median assimilation ratings for each excerpt
- as reported in Detert (2000)

Case	Therapy	Outcome	Median assimilation ratings by excerpt									
			1	2	3	4	5	6	7	8	9	10
159	CB	Poor	2.60	3.05	2.70	3.25	3.20	2.55	2.85	2.90	2.50	2.80
048	CB	Poor	1.50	1.35	1.80	1.65	2.00	1.55	3.55	2.55	2.35	3.00
150	PI	Poor	2.50	2.55	2.40	2.25	2.70	2.40	2.80	2.30	2.10	3.00
036	PI	Poor	2.00	1.65	3.25	2.95	2.75	1.35	1.50	2.10	2.55	3.85
110	CB	Good	3.15	4.40	2.70	5.95	4.05	5.60	3.30	4.10	3.65	3.85
153	CB	Good	2.05	2.05	4.05	4.85	1.40	2.35	4.70	4.35	4.70	4.55
140	PI	Good	3.40	2.55	4.25	3.10	3.20	2.60	3.15	6.05	4.65	3.05
132	PI	Good	2.30	4.00	1.85	4.05	3.30	2.60	1.95	3.10	2.60	2.35

Appendix 3: Summary of components of Therapist Focus on Action and Insight Scale - (TFAI: Samoilov et al. 1998)

Components	Description & examples of keywords *Therapists focuses on:*	Scale
Self-evaluation	Clients appraisal, judgement, estimation etc. of their own abilities or worth: "ashamed", "competent", "failure", "you like yourself", "feel helpless"	Constructing Meaning
Thought	Clients ides, opinions, beliefs, memories, interpretations, perceptions or evaluations of other person or things: "believe", "comprehend", "know", "understand", "learn", "examine"	
Intention	Clients wishes, needs, wants, plans, desires & motivations: "choose", "decided to", "need to", "want"	
Emotion	Clients feelings:"afraid", "guilty", "satisfied", "love", "missing"	
Intrapersonal link	Link between two or more components within the client	
Interpersonal link	Link between client components & another person's components	
Past	Infancy to time before therapy	
Situation	Circumstances external to client that are relevant to understanding clients' functioning: "After you woke up","alone","at home","at work"	Facilitating Action
Expectation	Clients anticipation of future outcome:"believe that", "expect that", "count on it","imagine that"	
Action	Clients performance or specific behaviours:"being friendly", "assertive","yawn"	
Current	Everyday life during course of therapy:	
Future	Occurring after current session	

Appendix 4: Summary of Experiencing scale - (Klein et al. 1969; Klein et al. 1986)

Stage	Description	Perspective
1	Talks about external events; refusal to participate; impersonal and detached, could be talking about stranger or object.	Progressive ownership of affective reactions
2	Behavioural or intellectual self-description of external events; interested, personal, self-participation, but see them from the outside only.	
3	Describes personal reactions to external events; limited self-descriptions; behavioural descriptions of feelings; is reactive and emotionally involved.	
4	Descriptions of feelings and personal experiences, but no effort to formulate/analyse; self-descriptive & associative.	Transition point – where content and focus shift from outside to inside, speaker's purpose is to describe phenomenology
5	Proposes problems with feelings and personal experiences; exploratory, elaborative and hypothetical.	Progressive expansion and integration of perspective.
6	Synthesis of readily accessible feelings and experiences to resolve personally significant issues; feelings vividly expressed, integrative, conclusive or affirmative.	
7	Full, easy presentation of experiencing; all elements confidently integrated; expansive, illuminating, confident, buoyant.	

Appendix 5: Summary of valency categories included in training manual for raters
- developed from Cooper (1990) & Barton (1999)

Valency category	Description & example sentences
Positive	Thoughts that facilitate coping, adaptive thoughts, realistic appraisal of situation and of oneself or other people, complimentary, praising, positive. Evoke situation in which there is satisfaction, contentment, harmonious relationship, optimism. "I have time for people" "She should not worry about that you can't control" "He's never said anything horrible" "I didn't mind working late"
Negative	Dysfunctional, maladaptive thoughts, involving unfavourable consequences, avoidance, escape, negative affect, confusion, uncertainty, rejection of. Evoke situations in which there is distressing emotion, unharmonious relationships, pessimism. "It's hard to tell what I'm like really" "I don't know" "And they always get really irritated" "My family have fallen apart" "I love to be awkward"
Neutral	All other statements e.g. simple descriptions, factual sentences without any affective or evaluative component. "He has gone to university" "I haven't' finished" "The country is where we walk the dogs"

APPENDIX 6: LETTER OF ETHICAL APPROVAL

Oxford Doctoral Course in Clinical Psychology

an NHS Course validated by the University of Oxford

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Our ref: mgp/mc

13 May 2002

Angharad Rudkin
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Dear Hari

Thank you for sending a revised ethics application form. I am pleased to say that you have generally addressed our concerns satisfactorily. Your response to 17 (b) perhaps does not quite do justice to the power of your study. Although the number of participants is relatively small, this might well (given the results of previous, smaller studies), and using appropriate statistics, be sufficient to produce some statistically significant findings. Moreover, as you will also be working with 80 data points as your data base, this will probably make the power of the study (analysed in this way) fairly good.

I am happy to approve your submission on behalf of the Course Ethics Committee and wish you every success with your project.

Best wishes.

Yours sincerely

Myra

Dr Myra Cooper
Research Tutor

cc: Gillian Butler
Hannah Turner
Sue Llewelyn

Appendix 7: Worked example of obtaining CM and FA scores - using the category "emotion" for first 8 utterances of client 159.

Case 159 was chosen to illustrate this process as there was a relatively small number of utterances per excerpt, thereby making it a clearer example to use. The first 5 excerpts only are shown for the sake of brevity.

Step 1: Collapsing raters' values

- entering raters' scores and obtaining the mode.

Excerpt 1		Rater 1	Rater 2	Rater 3	MODE
Utterance	1	0	0	0	0
	2	0	0	0	0
Excerpt 2					
	3	1	0	1	1
	4	0	0	0	0
Excerpt 3					
	5	0	0	0	0
	6	0	0	0	0
Excerpt 4					
	7	1	1	1	1
Excerpt 5					
	8	1	0	1	1

Step 2: Translating utterance scores into excerpt scores

- summing modes of utterances in excerpts

Excerpt 1		**MODE**	**Sum of modes for excerpt**
Utterance	1	0	0
	2	0	
Excerpt 2			
	3	1	1
	4	0	
Excerpt 3			
	5	0	0
	6	0	
Excerpt 4			
	7	1	1
Excerpt 5			
	8	1	1

Step 3: Amalgamating into CM scale.

- drawing together the sum of modes for CM categories for each excerpt

	Emotion	**Self-eval**	**thought**	**intention**	**Intra-personal**	**Inter-personal**	**past**	**Total for excerpt**
Excerpt 1	0	0	2	1	0	1	0	4
Excerpt 2	1	0	2	0	1	1	0	5
Excerpt 3	0	0	2	0	1	1	0	4
Excerpt 4	1	0	1	1	0	1	0	4
Excerpt 5	1	0	1	0	0	1	0	3

Step 4: Calculating percentages of CM per excerpt

- to get percentage CM score for each excerpt
- to take into account the different number of utterances in each excerpt.

Total CM for Excerpt 1 = 4
Total number of utterances in Excerpt 1 = 2
Percentage of CM categories endorsed in Excerpt 1 =

$$\frac{\textit{total CM for excerpts}}{\textit{number of utterances x number of CM categories}} \quad x\ 100$$

So, in this example, percentage of CM in Excerpt 1:

$$\frac{4}{2x7} \text{ x } 100 = 28.6\%$$

Repeated for each excerpt for CM scale, and the for FA scale.

Step 5: Amalgamating into CM and FA scales for client.

- drawing together the sum of modes for each excerpt for each CM category

	Emotion	Self-eval	thought	intention	Intra-personal	Inter-personal	past
Excerpt 1	0	0	2	1	0	1	0
Excerpt 2	1	0	2	0	1	1	0
Excerpt 3	0	0	2	0	1	1	0
Excerpt 4	1	0	1	1	0	1	0
Excerpt 5	1	0	1	0	0	1	0
Total modes for the 5 excerpts	3	0	8	2	2	5	0
Total CM score for the 5 excerpts	24						

Step 6: Calculating percentages of CM per client *(same procedure as calculating percentage CM per excerpt)*

- to get overall percentage CM score for each client
- take into account the different number of utterances in each excerpt.

Total CM for 5 excerpt = 24
Total number of utterances in 5 excerpts = 8
Percentage of CM categories endorsed in the 5 excerpts =

$$\frac{\textit{total CM for excerpts}}{\textit{number of CM categories x number of utterances}} \textit{ x 100}$$

So, in this example, percentage of CM in the first 5 excerpt for client 159 is:

$$\frac{24}{7x8} \text{ x } 100 = 42.8\%$$

Repeated for each client for CM scale, and then for FA scale

Appendix 8: Transcripts of excerpts showing the highest percentage of CM and FA scores for CB and PI therapy

- starting at the beginning of the excerpt and ending with the therapist's last substantial utterance

Key : **C**: client
T: therapist
CB=cognitive-behavioural therapy
PI = Psychodynamic-Interpersonal therapy

Constructing Meaning (CM) scale

Case 132 - PI therapy (excerpt 4)– CM rating for excerpt = 53.6%

C: I'm always worried that I'm going to upset him, but then of course it gets even worse and I start saying" I didn't upset you did I, by asking you?" and then I'm reassuring myself about that. I'm sure you can imagine. He's very cool, to be honest, he does, he does, nothing bothers him, so even if I do go on about things for hours he's not that bothered, he just takes the micky out of me and anything you know to sort of calm me down and then try and forget about it. But yeah I do worry about spoiling it by going on all the time.

T: So I'm wondering how much your health, your physical problems as a small child with your palate. Were really very, very, very frightening indeed.

C: I would say the are. They were , I mean I can't I can't remember an awful lot of it which lead me to believe they might have been. Although I an remember my mum telling me that the nurses at the hospital thought I was marvellous and I would entertain all the other children but I do feel could have been hiding an awful lot.

T: Yes, yes, a lot, a lot of really very, very panicky desperate feelings for a small child. And in some way, you've never quite dealt with that. I mean, you've dealt with it on the surface very well, of course, and you know, you've used and you've got all the ability that you've had to take you where you've got to and so on, but somehow inside you there's still this very sort of traumatised person.

C: Mm, yeah.

T: Who's looking for reassurance that, beyond the point, I mean you know its unreasonable, you can talk about it and its very, you know you can talk about it in a very insightful way, which of course in one way is great but in another way means that the pain is never really reached because you can snap out of it and you can, you can switch into that high node and you can be, you can be a bossy teacher and you can be an extrovert person having a good time.

C: Yeah, so no one would ever know unless I told them, yeah.

T: Yes, no one would ever know how you feel inside. No one would know the pain you feel.

Case 110 - CB therapy (excerpt 2) - CM rating for excerpt = 39.4%

C: In fact the other weekend I was up north Yorkshire with a friend that we have. We did try and sort through this problem with anger with our parents

'cos we both experience it and I think you know you shouldn't be angry with your parents. We feel guilty about it.
T: OK.
C: But it happens.
T: Yes. What..simple question..what would you like to be able to do?
C: If I'm really honest?
T: Yes.
C: Shut the door on the whole thing and walk away for a bit.
T: Right. What would happen if you did that?
C: Well I don't know. I suppose the....they would carry on with the social services they are now. In fact I've decided that I'm not going down for a bit, I'm going to leave things..let the dust settle for a bit. I think it would be wrong to go around stirring things up. I think I would be a source of trouble if I went down there. So I'm staying put.
T : OK.
C: I may be wrong but that's what I've decided.
T : So you've decided to stay in Sheffield?
C: Yeah well I went 3 weekends in six over the last...I went to see them for a weekend, then they were in hospital or the nursing home, I went then. Then I went when I camped out in their bungalow when they were both in the nursing home. And I think its time I left it for a bit.
T: What's your fears in some way? I mean...
C: I don't know.
T : Do you ever fear that somehow you're going to be sucked into it all?
C: yes.
T: And that obviously as they become frailer and weaker and there's more chance obviously of things happening, more demands being placed on you?

Facilitating Action (FA) scale

Case 36 – PI therapy (excerpt 8) – FA rating for excerpt = 29.3%
C: Trying to keep every job going.
T: A bit like a kind of..these sort of jugglers you know...
C: That's right.
T: Keep these plates spinning on the poles...
C: That's right, keep things going.
T: And running around trying to keep them all going...
C: Yeah. And I can't sit back you know I should sit back you know and think well they can manage without me anyway, nobody is indispensable but...
T: You can say that.
C: Yes but,
T: But somehow its difficult for you to
C: To act on it..it's mm....
T: Just somehow you your frightened that if you did try that you know that many of the plates stopped and smash, something would happen.
C: Happen mm. Yes, I mean it's a bit like that and I just don't know. I think what I've got to try and..is to try and say what I mean, I think I've got to practice this I've got to practice saying to people 'well you will have to

wait, I have to go to see this first or that'. I have to steady down I suppose but when the time comes to think, I think about doing things but when the time comes I just can't, I just...I think well..what does it matter you know.
T: When the time comes you say to yourself 'what does it matter?'
C: Mm, if I'm helping someone and I'm going round in circles keeping them happy suppose.
T: That almost sounds like its saying 'what does it matter what I do to myself, as long as other people are happy'.

<u>Case 153 – CB therapy (excerpt 1) – FA rating for excerpt = 64%</u>
C: There's me who's originally, well 90 percent will come, but J who were in the same office with me who's been moved, seconded up, she's got everybody going round the back door talking to her rather than coming through the system and , I don't; know, I think she likes it but I don't.
T: So part of it is the problem between you and the, with J who's been seconded? And she was somebody who worked in the office?
C: She was the same level as me. I was the original cos I've come through the authority for nine years. And she were appointed outside about three years ago.
T: To the same?
C: To the same level yeah. And then things happened in the authority and..
T: And now she's..
C: She's my gaffer now, she's my boss. You see, my boss before, M, she let us run it as a manager should run it, but J seems to be delegating and telling us what to do when I know I can do it myself, without her telling me.
T: So she doesn't really effectively let you manage yourself. And you think that's the crux of difficulties, that's, that's what's..
C: Plus she's got a difference personality than everybody else I've worked for.
T: In what sense, how's she different?
C: Well everybody I've worked with I've got on with. I get on with J, don't get me wrong, you know what I mean, but she's the one who's a bit of a dictator. You know, and jumps first and then she might be wrong after but I went, I've been on a course for 3 days this week, and B, who's our personnel officer, he just said summat and it clicked in my head, he says its about time you turned around to balk back at em, he says cos I imagine that they're never right, well I mean its to be proved like that's what he said. And it just clicked in me head, so I though oh, And he's right, you know what I mean. So summat clicked in my head to say its bout time I stuck up for myself, in a roundabout way, rather than turn round and say, accept it that she's right all the time.
T: So, the the just this week doing that course, and what was the course that you?
C: All it were, it were, we did it all departmentalled you see, and it were a refresher course for all the supervisors under us and he turned round to supervisors and says "your managers are not" cos they do the job you see they do all the cleaning and that, they say "your managers might not be right, you might be right", so of course it triggered off up the line you see,

so I thought well he's right on what he just said to me. That, I mean I'm not always right I'll admit it, you know that I mean, and it just triggered it off.
T: And so, thinking, I mean is it, is that one thing that's happened is that you haven't, you've not stuck up for yourself with J, you've not challenged her, but inside you've got all...

Appendix 9: Transcripts of excerpts showing the highest experiencing scores in CB and PI therapy.

Key: EXP=experiencing
CB=Cognitive-behavioural therapy
PI = Psychodynamic-Interpersonal therapy

CB therapy

Case 48 – CB therapy (excerpt 10) – mode EXP= 4, peak EXP= 5

T:Right. Why, why I'm saying that is to get to appoint of saying "well look", for you to recognise that you have to change that way of being. In other words, being thought well of has not, need, you know, setting things up and trying to be thought well of hasn't actually given you what you wanted.
C:No, it hasn't, no.
T: hasn't given you the friends you wanted, it hasn't given you the relationship with you mum that you wanted, quite, I'm not quite sure about the relationship with S but the, but it doesn't seem to have actually led you to a point where you can say you feel happy. So in w way being thought well of hasn't delivered the goods.
C:Mm.
T:In some way. What's an alternative strategy? What's another way of going about it?
C:Feeling good about myself rather than having, expecting others to feel that they like me and things.
T:OK.
C:Starting to like myself.
T:OK. And what do you think might be the consequence of that?
C:Well if I like myself I'll, if I can get to the stage where I like myself I'll probably stop worrying about whether people like me or not and still end up with some good friends. But I mean I can see that but it's so difficult to actually bring about change like that.

PI therapy

Case 140 – PI therapy (excerpt 9)– mode EXP=5, peak EXP= 5.3

C: Well I think, like said, you probably hit the nail on the head in the fact that I've been fighting a lifetime I think, with not being dependent upon someone else. I've always been striving to be independent and I'm. I'm trying to make habits go away of, of accepting things tat this, I', happy in what I'm doing, being together. And accepting that sometimes its, I can't move things at my pace. They need to move.
T: Yeah, part of being involved with someone is that you won't always get your own way.
C: Yeah, that's true. And I realise that but that you know, I, I've never really looked at it like that. I've always looked at it as when I've been in anything I'm setting the rules and the pace and the limits and the boundaries. But somehow maybe I'm just going to have to go over those boundaries if I want the relationship to move on.

Appendix 10: Examples of clients' self-statements from excerpts rated with varying percentage of negative valency.

N.B. the brackets around the utterances denote the beginning and end boundaries of idea units, which were the units of analysis.

Case 159 (excerpt 9) = 0% negative. [Yeah, I feel, I feel somewhat reassured that there] [that maybe I've not being doing as bas a job as I thought I was doing] [and that there's a role for me to play there].
Case 36 (excerpt 10) = 25% [I think I do worry too much][that's I think that's the problem][too much of a worry] [I'm going to try]
Case 140 (excerpt 6) = 50% negative. [So its not so much an ultimatum as it is just the fact is I just don't want to lose] [I feel disappointed] [I wouldn't say I'm angry] [I feel, I think that maybe that's one of the reasons I'm] [I have been, or I was or am, I don't know, very close to this other friend that I've had for 22 years]. [And that's what I'm saying. It's disappointing for me to think that I can give now and I'm not even being able to] [I don't know its] [I think its easier not to care] [and just not give and not get, not get involved] [but each time I go through that I think 'no' because the, the experiences I've had and the pleasures] [you can't, you can't take them away].
Case 48 (excerpt 2) = 75% negative [I don't know] [Well yes and no] [sometimes I think it would be better if I didn't][I can't decide]. [Yeah, I think that's what I want]
Case 110 (excerpt 1) = 100% negative. [I think 'Oh God'] [I don't know] [it's sort of anger I think] [And the guilt at not being able to do anything] [and not you know what ever I do it seems to be wrong anyway]